Latitude AI Health Plan Notices

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IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Latitude AI LLC About Your Prescription Drug Coverage and Medicare."

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Latitude AI LLC	92-1130676
5. Employer address	**6. Employer phone number**
2545 Railroad Street	412-709-6992

7. City	8. State	9. ZIP code
Pittsburgh	PA	15222

10. Who can we contact about employee health coverage at this job?	
Latitude AI Benefits Team	
11. Phone number (if different from above)	**12. Email address**
	benefits@lat.ai

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:

    Employees who work an average of 30 hours per week and exempt employees who work an average of 20 hours per week.

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Legal spouse, domestic partner and dependent child(ren) up to age 26.

  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☑ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ $35.00
b. How often? ☐ Weekly ☑ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $ _____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NO SURPRISE BILLING NOTICE
Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers may be out-of-network. In these cases, the most that those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

More information about your state rights and protections

As of February 2021, the following 18 states had enacted comprehensive Balance Billing Protections: California, Colorado, Connecticut, Florida, Georgia, Illinois, Maine, Maryland, Michigan, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon, Texas, Virginia, and Washington.

As of February 2021, the following 15 states had enacted limited Balance-Billing Protections: Arizona, Delaware, Indiana, Iowa, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, North Carolina, Pennsylvania, Rhode Island, Vermont, and West Virginia.

Generally, those state passed protections apply to fully insured medical plans governed by the specific state and not self-funded medical plans which are covered under the federal law. The chart below contains state specific balance billing or relevant information and resources, if any, including contact information for state agencies that may be able to help you further. Check the state insurance commissioner website for details on specific state laws.

If your state is not listed above or included in the chart below, check your state commissioner's website as states may adopt a surprising billing mandate at any time.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may file a complaint with the federal government at https://www.cms.gov/nosurprises/consumers or by calling 1-800-985-3059; and/or file a complaint with your state balance billing regulator, if any, which is identified in the chart below.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law or visit your home state regulator's website (included in state links below) for more information about your state balance billing rights.

ARIZONA	Arizona law protects patients from surprise medical bills for: 1. Emergency services and health care services directly related to the emergency services provided during an inpatient admission by an out-of-network provider at an in-network facility; and 2. Non-emergency health care services provided by an out-of-network provider at an in-network facility, if the out-of-network provider did not provide the patient or his or her authorized representative a written disclosure prior to the health care service or the patient or his or her representative chose not to sign the referenced disclosure. The law applies to patients with coverage through a disability insurer, group disability insurer, blanket disability insurer, hospital service corporation or medical service corporation that provides health insurance in AZ. This law does not apply to any health plans that do not include coverage for out-of-network health care services. Additionally, AZ law prohibits hospitals or providers from charging patients with coverage through a health maintenance organization (HMO) more than the amount a hospital or provider agreed to accept from the HMO. For more information regarding your protections against surprise billing, contact or visit: **Arizona Department of Insurance and Financial Institutions** Address: 100 N. 15th Ave. Ste. 261, Phoenix, AZ 85007-2630 Phone: (602) 364-3100 E-mail: soonbdr@azinsurance.gov Website: https://difi.az.gov/arizonas-surprise-out-network-billing-dispute-resolution-soonbdr-program
CALIFORNIA	California law protects enrollees in state regulated plans from surprise medical bills when the following occur: (a) an enrollee receives emergency services from a doctor or hospital that is not contracted with the patient's health plan or medical group; or (b) an enrollee receives scheduled care at an in-network facility such as a hospital, lab, or imaging center, but services are delivered by an out-of-network provider. In covered circumstances, providers cannot bill consumers more than their in-network cost sharing. Further, for uninsured individuals, hospitals must provide the patient with a written estimate of the amount the hospital will require for the expected services at the time of service. You may also be protected under California law for any non-emergency services that you receive from out-of-network providers and in-network facilities, in which case the most you can be billed is your in-network copayments, deductibles, and/or coinsurance. ***If, however, you provide written consent to receive nonemergency services from an out-of-network provider, you may be balance billed or you may be responsible for the entire bill.*** For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **California Department of Insurance** Phone: 1-800-927-4357 Website: http://www.insurance.ca.gov/01-consumers/101-help/index.cfm OR https://www.insurance.ca.gov/01-consumers/110-health/60-resources/NoSupriseBills.cfm OR https://www.dmhc.ca.gov/Portals/0/HealthCareInCalifornia/FactSheets/fsab72.pdf

COLORADO	Colorado protects patients covered by state-regulated insurance plans (you have a "CO-DOI" on your health insurance ID card) from surprise medical bills for health care services provided at an in-network facility by an out-of-network provider. Colorado also protects patients from surprise medical bills for emergency services, even if the emergency services are out-of-network or provided by an out-of-network provider. Colorado law requires that patients pay only their in-network cost sharing amounts. Colorado law does not protect patients from surprise medical bills when the patient intentionally uses an out-of-network provider. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Colorado Department of Regulatory Agencies, Division of Insurance, Consumer Services Division** Phone: 303-894-7490 or 1-800-930-3745 Email: DORA_Insurance@state.co.us Website: https://www.colorado.gov/pacific/dora/DPO_File_Complaint OR https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/out-of-network-h ealth-care **Office of the Attorney General** Address: 1300 Broadway, 10th Floor, Denver, CO 80203 Phone: (720) 508-6000 Website: https://coag.gov/file-complaint/
CONNECTICUT	Connecticut passed its own law in 2015 to address balance billing. The law applies to health plans regulated by Connecticut's Department of Insurance and has similar protections to those provided under the federal No Surprises Act. For more information, please see Conn. Gen. Stat. §§ 38a-477aa and 20-7f. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Connecticut Department of Insurance** Phone: (800) 203-3447 or (860) 297-3900 Website: https://portal.ct.gov/CID/General-Consumer-Information/No-Surprises-Act The State of Connecticut Office of the Healthcare Advocate Phone: 866-466-4446 Email: Healthcare.advocate@ct.gov

DELAWARE	Delaware protects patients from balance billing for: (i) any covered medically necessary services performed by an out-of-network provider, when the medically necessary service is not available through in-network providers in a reasonable amount of time, provided the patient has a referral; and (ii) emergency services from an out-of-network provider. Additionally, Delaware also protects patients for: (i) covered non-emergency services provided at an in-patient or ambulatory facility by an out-of-network provider and/or at out-of-network facility; and (ii) covered non-emergency services provided by an out-of-network provider, unless the patient received and consented to a written disclosure. This protection allows patients to be billed for in-network cost-sharing amounts. These protections apply to patients with coverage through any policy or contract for health insurance delivered or issued in Delaware. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Delaware Department of Insurance** Phone: 1-800-282-8611 (In Delaware Only) Or (302) 674-7310 Email: consumer@delaware.go website: https://insurance.delaware.gov/services/filecomplaint/
FLORIDA	In the state of Florida, there are comprehensive balance billing protections in addition to those provided by the federal No Surprises Act. Florida law states that insurance companies are not allowed to bill you for amounts beyond your plan's in-network cost-sharing amount. That protection applies to HMO and PPO insurance plans for emergency services by out-of-network providers and facilities, as well as non-emergency services provided by out-of-network providers at in-network facilities. For PPOs, the state payment standard applies to emergency services and non-emergency services provided by out-of-network providers at in-network facilities. For HMOs, the state payment standard only applies to emergency services but the state also has a claim dispute resolution program in place. Under Florida law, these protections do not apply to ground ambulance services for PPO insurance plans, patients enrolled in PPO insurance plans who consent to non-emergency out-of-network services, and patients with self-funded insurance plans. The laws put in place by the state of Florida work together with the requirements of the No Surprises Act to ensure that you are protected from surprise medical bills. Florida has not designated a surprise billing enforcement agency, but you can contact the **Florida Department of Financial Services, Division of Consumer Services** at 1-877-MY-FL-CFO.

GEORGIA	Georgia law generally contains balance billing protections similar to those under the No Surprises Act (as described in this Notice), for individuals enrolled in fully funded commercial plans, such as preferred provider ("PPO") plans, and health maintenance organization ("HMO") plans. If you have one of these plans, Georgia also extends the balance billing protections to covered emergency and non-emergency medical services provided by nonparticipating providers in participating birthing centers, diagnostic and treatment centers, hospices or similar institutions. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Office of Commissioner of Insurance** Address: 2 Martin Luther King Jr. Dr., West Tower, Suite 702, Atlanta, GA 30334 Phone: (404) 656-2070 Website: https://oci.georgia.gov/ If you have a Georgia PPO or HMO plan and think you've been wrongly billed by your health care provider, you may file a complaint with the Georgia Consumer Protection Division by calling (404) 651-8600 or visiting https://consumer.georgia.gov/resolve-your-dispute/how-do-i-file-complaint. If you believe you have received an improper bill from your health plan, you may file a complaint with the Office of Commissioner of Insurance and Safety Fire by emailing consumercomplaints@oci.ga.gov or visiting https://oci.georgia.gov/file-consumer-insurance-complaint.
ILLINOIS	Illinois protects patients from balance billing for: (i) covered medical services at an in-network hospital or ambulatory surgical center provided by an out-of-network facility-based provider, if (a) the patient has agreed in writing to assign their benefits to the out-of-network provider, (b) an in-network facility-based provider is unavailable and (c) the patient did not willfully choose the out-of-network provider; and (ii) covered emergency services at an out-of-network facility or provided by an out of network provider. This protection does not prohibit the imposition of in-network cost-sharing amounts. This protection applies to all insurers providing accident and health insurance, including health maintenance organizations ("HMOs"). Illinois law also protects patients from surprise medical bills for patients that have made a good faith effort to utilize in-network providers, but it is determined that the insurer does not have the appropriate in-network providers. In this case, the insurer must ensure that the beneficiary will be provided the covered service at no greater cost than if the service had been provided by an in-network provider. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Illinois Department of Insurance** Phone: (877) 527-9431 Website:https://www2.illinois.gov/sites/Insurance/consumers/Pages/default.aspx

INDIANA	Indiana law protects patients from balance billing for non-emergency services provided by out-of-network providers at in-network facilities. This protection does not apply if a patient has received advanced notice from an out-of-network provider and consents to the pricing of the healthcare services. This protection limits the financial liability of patients to the rate paid to the out-of-network provider by the covered individual's network plan plus any in-network cost-sharing amounts. This prohibition applies to all patients with coverage through a network plan. Indiana also protects patients with coverage through an HMO from balance billing for: emergency services received from an out-of-network provider or at an out-of-network facility and any covered services performed by an out-of-network provider when the covered service is not available through in-network providers, provided the patient has a referral. Indiana law requires the patient to pay only in-network expenses. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Indiana Department of Insurance, Consumer Service Department** Address: 311 West Washington Street, Suite 300, Indianapolis, IN 46204-2787 Phone: 1-800-622-4461 or 317-232-2395 Email: consumerservices@idoi.in.gov Websites: https://content.govdelivery.com/accounts/INDOI/bulletins/29ac870 OR https://www.in.gov/idoi/consumer-services/
IOWA	Iowa law requires state regulated insurance plans and public employee plans to cover all emergency services, including emergency services provided by out-of-network providers. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Iowa Insurance Division** Phone: 515-654-6600 Website : https://iid.iowa.gov/contact

MAINE	Maine law protects patients from balance billing for "surprise bills" and for covered emergency services rendered by an out-of-network provider. A surprise bill is a bill for health care services received by an enrollee for covered services rendered by an out-of-network provider when the services were rendered at a network provider, during a service or procedure performed by a network provider, or during a service or procedure previously approved or authorized by the insurance carrier and the enrollee did not knowingly elect to obtain such services from that out-of-network provider. Such patients are only required to pay the applicable coinsurance, copayment, deductible, or other out-of-pocket expense that would be imposed for the health care services if the services were rendered by a network provider. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Maine Bureau of Insurance** Address: 34 State House Station, Augusta, ME 04333 Phone: 207-624-8475 or 800-300-5000 Email: insurance.pfr@maine.gov Website: https://www.maine.gov/pfr/insurance/ OR Maine Statute 1718-D Prohibition on balanced billing for surprise bills

MARYLAND	If you are in a Health Maintenance Organization (HMO) governed by Maryland law, you may not be balance billed for services covered by your plan. If you are in a PPO or EPO governed by Maryland law, hospital-based or on-call physicians paid directly by your PPO or EPO (assignment of benefits) may not balance bill you for services covered under your plan and can't ask you to waive your balance billing protections. If you believe you've been wrongly billed, you may contact the Health Education and Advocacy Unit (HEAU) of Maryland's Consumer Protection Division: **Health Education and Advocacy Unit, Office of the Attorney General** 200 St. Paul Place, 16th Floor Baltimore, Maryland 21202 Phone: 410-528-1840 or toll-free -877-261-8807 En español: 410-576-6571 Fax: 410-576-6571 Website: https://www.marylandattorneygeneral.gov/Pages/CPD/HEAU If you believe your health plan processed your claim incorrectly, you may contact the Maryland Insurance Administration: **Maryland Insurance Administration, Life and Health Complaints Unit** Address: 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202 Phone: 410-468-2000 or toll free 1-800-492-6115 Fax: 410-468-2260 E-mail: insurance.mia@maryland.gov Websites: www.insurance.maryland.gov OR https://insurance.maryland.gov/Consumer/Documents/publications/AssignmentofBenefitsFAQ.pdf

MASSACHUSETTS	Massachusetts law protects patients from balance billing when receiving emergency services, if patients do not have a reasonable opportunity to utilize a preferred provider. Massachusetts also protects patients from balance billing when patients receive (i) covered non-emergency services from an out-of-network provider when patients did not receive notice that the provider was out-of-network; (ii) covered medically necessary services from an out-of-network provider when such services are not available in-network,; (iii) covered medically necessary services from an out of network provider at an in-network facility, if patients did not have a reasonable opportunity to choose an in-network provider. These protections apply to patients with coverage through insurers licensed to transact accident or health insurance, a nonprofit hospital service corporation, a nonprofit medical service corporation, a health maintenance organization ("HMO"), and preferred provider organization ("PPO"). These protections only require patients to pay the amount required for in-network services. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Massachusetts Division of Insurance, Consumer Service Unit** Phone: 617-521-7794 Website: www.mass.gov/how-to/filing-an-insurance-complaint **Massachusetts Attorney General** Phone: 888-830-6277 Website: www.mass.gov/how-to/file-a-health-care-complaint **Health and Human Services of the Commonwealth of Massachusetts** Address: 1 Ashburton Place, 11th Floor Boston, Massachusetts 02108 Phone: (617) 573-1600
MICHIGAN	Michigan law protects patients from balance billing and requires that the patient pay only their in-network cost sharing amounts for: (i) covered emergency services provided by an out-of-network provider at an in-network facility or out-of-network facility; (ii) covered nonemergency services provided by an out-of-network provider at an in-network facility if the patient does not have the ability or opportunity to choose an in-network provider; and (iii) any healthcare services provided at an in-network facility from an out-of-network provider within 72 hours of a patient receiving services from that facility's emergency room. Additionally, Michigan law states if the patient consents to receive non-emergency care from an out-of-network provider, the balance billing prohibition does not apply. These protections apply to any patient covered by a Michigan health benefit plan and a self-funded plan established or maintained by the state or local unit of government for its employees. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Michigan Department of Insurance and Financial Services** Phone: 877-999-6442 Websites: https://www.michigan.gov/difs/0,5269,7-303-13222_13250-561696--,00.html OR https://www.michigan.gov/DIFScomplaints

MINNESOTA	In addition to federal law, Minnesota law provides Minnesota residents with similar rights and protections against surprise medical bills for emergency services and unauthorized provider services provided by out-of-network health care providers. Minnesota balance billing statutes protect against: ● Emergency services provided at out-of-network hospitals or other emergency facilities. See 62Q.55 EMERGENCY SERVICES. ● Out-of-network services provided at in-network facilities. See 62Q.556 UNAUTHORIZED PROVIDER SERVICES. ● In-network provider discounts. See 62K.11 BALANCE BILLING PROHIBITED. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Minnesota Department of Commerce** Phone: (651) 539-1600 or (800) 657-3602 Website: https://mn.gov/commerce/about/contact/
MISSISSIPPI	In addition to the protections under federal law, Mississippi law prohibits balance billing for emergency care from facilities or providers that are out-of-network for those patients with state-regulated health plans. Mississippi law states that if a healthcare provider accepts a patient's insurance assignment from a state-regulated health plan, then the plan will pay the provider directly for the patient's treatment. That payment is considered payment in full to the healthcare provider – this means the provider cannot bill the patient later for any amount more than the payment received from the plan, other than normal deductibles or co-pays. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Mississippi Insurance Department, Office of the Insurance Commissioner** Address: Mississippi Insurance Department, P.O. Box 79, Jackson, MS 39205 Phone: 601-359-3569 or 1-800-562-2957 Websites: http://www.mid.ms.gov; https://www.midhelps.org/insurance-guide/balance-billing/ OR http://www.mid.ms.gov/healthcare/questionsanswers/TopicTwo.pdf

MISSOURI	Missouri protects patients from surprise medical bills for health care services provided at an in-network facility from an out-of-network provider from the time the patient presents with an emergency medical condition until the patient is discharged. Additionally, Missouri law requires that patients pay only their in-network cost-sharing amounts. These protections apply to any patient covered by a state-regulated insurance plan but does not apply to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Missouri Department of Insurance** Address: PO Box 690, Jefferson City, MO 65102-0690 Phone: (573) 751-4126 or 800-726-7390 Email: news@difp.mo.gov website: https://insurance.mo.gov/consumers/complaints/index.php
NEBRASKA	In accordance with the Nebraska Out-of-Network Emergency Medical Care Act, if you receive emergency services from any health care providers, such providers are not permitted to bill you in excess of any deductible, copayment, or coinsurance amount applicable to in-network providers' emergency services pursuant to your health benefits plan. Your insurer is obligated to make sure you do not incur out-of-pocket costs greater than the out-of-pocket costs you would have incurred had you received emergency services from an in-network health care provider. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Nebraska Department of Insurance** Phone: 402-471-2201, or call toll-free consumer hotline at 1-877-564-7323 Websites: www.doi.nebraska.gov OR https://doi.nebraska.gov/sites/doi.nebraska.gov/files/doc/ConsumerFactSheetBalanceBillingandOutofNetwor kProviders.pdf OR https://doi.nebraska.gov/consumer/consumer-assistance

NEVADA	Nevada law protects patients covered by health benefit plans regulated by the state, the Public Employees' Benefits Program, and third parties that opt into the prohibition from balance billing for medically necessary emergency services provided by an out-of-network provider. Additionally, Nevada law requires that the patient pay only their in-network cost-sharing amounts. This law does not apply to: (1) any patient who has coverage through an out of state insurance policy; (2) critical access hospitals or any medically necessary emergency services provided at such a hospital and (3) any out-of-network healthcare services provided 24 hours after notification that a patient has been stabilized. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Department of Business and Industry, Nevada Division of Insurance** Phone: 1-888-872-3234 Website: https://doi.nv.gov/Consumers/Health_and_Accident_Insurance/Balance_Billing_FAQs **Nevada Department of Insurance, Consumer Compliance & Licensing** 1818 E. College Pkwy., Suite 103 Carson City, NV 89706 Phone: (775) 687-0700
NEW HAMPSHIRE	New Hampshire state law protects you from having to pay more than your standard copays deductibles, or coinsurance for emergency services you get at an in-network hospital or surgical center, from anesthesiology, radiology, emergency medicine, or pathology service providers—even if those providers are not in-network for your insurance plan. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **New Hampshire Insurance Department** Address: 21 South Fruit Street, Suite 14, Concord, NH 03301 Phone: 603-271-2261 or 1 (800) 852-3416 TYY/RDD Relay Services: (800) 735-2964 Email: consumerservices@ins.nh.gov websites: https://www.nh.gov/insurance/consumers/ OR https://www.nh.gov/insurance/consumers/documents/20211210-nsa-faq-consumers-producers.pdf

NEW JERSEY	New Jersey law prohibits out-of-network providers and health care facilities in New Jersey from balance billing patients in excess of the patient's deductible, copayment, or coinsurance amount applicable to in-network services for (i) emergency or urgent medically necessary services, and (ii) inadvertent out-of-network services. New Jersey law defines "inadvertent out-of-network services" as health care services (1) covered under a managed care health benefits plan that provides a network; and (2) provided by an out-of-network provider at an in-network health care facility when in-network services are unavailable at that facility. This protection applies to all carriers operating in New Jersey with regards to health benefits plans issued in New Jersey, including self-funded plans that opt-in. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **New Jersey Department of Banking and Insurance** Address: State of 20 West State Street P.O. Box 325 Trenton, New Jersey 08625-0325 Phone: (609) 292-7272 Email: marlene.caride@dobi.nj.gov Website:https://www.state.nj.us/dobi/division_consumers/insurance/outofnetwork.html
NEW MEXICO	New Mexico protects patients from balance billing when patients receive: (i) emergency services from an out-of-network provider or provided at an out-of-network facility; (ii) covered non-emergency services provided by an out-of-network provider at an in-network facility if the patient did not have the ability or opportunity to choose an in-network provider; and (iii) medically necessary care from an out-of-network provider when an in-network provider is unavailable within a patient's network. Additionally, New Mexico law states that if a patient chooses to receive non-emergency care from an out-of-network provider, the balance billing protection does not apply. These protections only require patients to pay their in-network cost-sharing amounts. This protection applies to any entity subject to New Mexico's insurance laws. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **New Mexico Office of Superintendent of Insurance, Managed Care Bureau** Phone: 1-855-4-ASK-OSI Website: https://www.osi.state.nm.us/ **New Mexico Licensing and Regulation Department** Address: PO Box 25101, Santa Fe, NM 87504 Phone: (505) 469-0982

NEW YORK	For patients in New York and services referred by an in-network doctor, if your insurance ID card says "fully insured coverage," surprise bills include when your in-network doctor refers you to an out-of-network provider without your consent (including lab and pathology services). These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. You may need to sign a form (available on the Department of Financial Services' website) for the full balance billing protection to apply. These rights and protections are different from those described in Your Rights and Protections Against Surprise Medical Bills. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **New York State Department of Financial Services** Address: 1 State Street, New York, NY 10004-1511 Phone: (800) 342-3736 E-mail: consumers@dfs.ny.gov OR Surprisemedicalbills@dfs.ny.gov Websites: http://www.dfs.ny.gov/consumers/health_insurance/surprise_medical_bills or https://www.dfs.ny.gov/consumers/health_insurance/protections_federal_no_surprises_act
NORTH CAROLINA	North Carolina law protects patients from surprise medical bills for emergency services to the extent necessary to screen and to stabilize the patient when provided by an out-of-network provider. Additionally, North Carolina law requires that patients pay only their in-network cost sharing amounts. This law applies to patients with coverage through insurance companies licensed by North Carolina, health maintenance organizations, service corporations, and multiple employer welfare arrangements. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **North Carolina Department of Insurance** Phone: 855-408-1212 Website: www.ncdoi.gov

OHIO	Ohio law protects patients from balance billing and requires patients to pay their in-network cost sharing amounts for: (i) emergency services provided by an out-of-network provider or provided at an out-of-network emergency facility; and (ii) medical services provided by an out-of-network provider at an in-network facility if a patient did not have the ability to request an in-network provider. For services provided to a covered patient by an out-of-network provider at an in-network facility, a patient cannot be balance billed unless the patient is informed, provided with a good faith estimate of the cost of the healthcare services, and consents. Additionally, the Ohio law applies to patients covered under state-regulated insurance plans and insurance plans subject to the jurisdiction of the superintendent of insurance. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Ohio Department of Insurance** 50 W Town Street Suite 300, Columbus Ohio 43215 Phone: 800-686-1526 Website: https://insurance.ohio.gov/wps/portal/gov/odi/consumers/health/surprise-billing
OREGON	Oregon protects patients from balance billing for emergency services or other inpatient or outpatient services provided at an in-network facility. Additionally, Oregon law requires that patients pay only their in-network cost-sharing amounts for in-network facilities. This protection applies to any patient with coverage through any hospital expense, medical expense, or hospital/medical expense policy; subscriber contract of a health care service contractor; or multiple employer welfare arrangement plan. It does not apply to non-emergency services when patients choose to receive the services from an out-of-network provider. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Division of Financial Regulation, Department of Consumer and Business Services** Address: P.O. Box 14480, Salem, OR 97309-0405 Phone: 888-877-4894 Website: https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx OR https://dfr.oregon.gov/laws-rules/Documents/Bulletins/bulletin2018-02.pdf

PENNSYLVANIA	Pennsylvania law provides that managed care plans, including health maintenance organizations and gatekeeper, preferred provider organizations, and subcontractors of managed care plans cannot deny any claim for emergency services on the basis that the patient did not receive permission, prior approval, or referral prior to seeking emergency service. A managed care plan that has no in-network providers available to provide covered services shall cover services provided by an out-of-network provider. The plan shall cover the out-of-network services at the same level of benefit as an in-network provider. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Pennsylvania Department of Insurance** Address: 1326 Strawberry Square, Harrisburg, PA 17120 Phone: (717) 787-0872 or 1-877-881-6388 Website: https://www.insurance.pa.gov/Coverage/health-insurance/no-surprises-act/Pages/default.aspx OR https://pennpirg.org/sites/pirg/files/resources/PennPIRG%20Surprise%20Billing%20tip%20sheet_for matted. docx_.pdf
RHODE ISLAND	Rhode Island requires insurers to hold enrollees harmless for amounts beyond the in-network level of cost-sharing. This protection applies to HMO enrollees for (1) emergency services, and (2) non-emergency services provided by out-of-network professionals at in-network facilities. The state protection does not apply to PPO enrollees, ground ambulance services, or enrollees of self-funded plans. Rhode Island has not designated a surprise billing enforcement agency, but you can reach out to: ● The Rhode Island Department of Business Regulation Insurance Division at (401) 462-9520 or submit a complaint at https://sbs.naic.org/. ● The Rhode Island Office of the Health Insurance Commissioner by calling RIREACH toll-free: 1- (855)-747-3224 or at http://www.ohic.ri.gov.
TENNESSEE	Although Tennessee has not enacted any surprise billing regulations, current Tennessee law prohibits healthcare facilities from collecting out-of-network charges from a patient, or the patient's insurance in excess of the in-network cost-sharing amount unless the healthcare facility provided written notice to the patient prior to the provision of medical services and documented whether the patient signed the written notice. This law applies to any state-regulated insurance plan. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Tennessee Department of Commerce and Insurance** Phone: 615-741-2218 or 1-800-342-4029

TEXAS	Texas law protects patients with state-regulated health insurance (about 16 percent of Texans) from surprise medical bills in emergencies or when they didn't have a choice of doctors. The law bans doctors and providers from sending surprise medical bills to patients in those cases. Texas law also prohibits balance billing for any health care, medical service, or supply provided at an in-network facility by an out-of-network physician or other provider and for services by diagnostic imaging providers and laboratory service providers provided in connection with a health care service performed by a network physician or provider. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Texas Department of Insurance** Phone: 800-252-3439 Website: https://www.tdi.texas.gov/tips/texas-protects-consumers-from-surprise-medical-bills.html OR https://www.tdi.texas.gov/medical-billing/surprise-balance-billing.html
UTAH	Although Tennessee has not enacted any surprise billing regulations, current Utah law protects patients with coverage from a health insurance policy or managed care organization from balance billing for emergency services. Additionally, Utah law states that a patient receiving services at an in-network facility may not be held responsible for more than the in-network cost-sharing amount. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Utah Insurance Department, Health Insurance Consumer Service** Phone: (801) 957-9280
VERMONT	Vermont law states that a physician who agrees to treat a Medicare or General Assistance beneficiary may not balance bill the beneficiary unless: (1) during the calendar year prior to treatment, the Medicare beneficiary (or his or her spouse with whom he or she lived at any time during that year) received Social Security benefits or railroad retirement benefits which were subject to federal income taxation or would've been if they received them; (2) the Medicare beneficiary refuses to sign the statement authorized by 33 V.S.A. § 6504; or (3) the service for which the beneficiary is to be billed is either an office or home visit. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Vermont Department of Health, State Board of Medical Practice** Phone: (802) 657-4220 Email: AHS.VDHMedicalBoard@vermont.gov

VIRGINIA	Consumers covered under (i) fully insured policies issued in Virginia, (ii) the Virginia state employee health benefit plan; or (ii) as self-funded group or plan that opted in to the Virginia protections area also protected from balance billing under Virginia law. These protections may be different from the ones provided by the federal law as described in Your Rights and Protections Against Surprise Medical Bills. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Virginia State Corporation Commission Bureau of Insurance** Address: Bureau of Insurance – SCC, P.O. Box 1157, Richmond, Virginia 23218 Phone: 877-310-6560 Email: bureauofinsurance@scc.virginia.gov; Websites: https://scc.virginia.gov/pages/Balance-Billing-Protection and https://scc.virginia.gov/getattachment/c9bb945e-2b7c-448a-a940-9ba939f15b25/BB-Complaint-Form.pdf
WASHINGTON	Starting Jan. 1, 2020, Washington state law protects you from surprise or balance billing if you receive emergency care at any medical facility or when you're treated at an in-network hospital or outpatient surgical facility by an out-of-network provider. Please note that Washington law does NOT apply to ALL Washington health plans. It only applies to certain state insured plans. If Washington law does NOT apply, you may still be protected under Federal balance billing prohibitions. If you are protected under Washington law, your provider, hospital, or facility must refund any amount you overpay within 30 business days. For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Washington Office of the Insurance Commissioner** Phone: 800-562-6900 Websites: https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status OR https://www.insurance.wa.gov/what-consumers-need-know-about-surprise-or-balance-billing
WEST VIRGINIA	West Virginia requires insurers to provide coverage for emergency medical services--including prehospital services--to the extent necessary to screen and stabilize an emergency medical condition without requiring prior authorization for the screening services or stabilization of the emergency medical condition. Such coverage of emergency services is subject to coinsurance, copayments, and deductibles applicable under the health benefit plan. W. Va. Code Section 33-25A-8d(b)(3). For more information regarding your protections against surprise billing or to learn about making a complaint, contact or visit: **Offices of Insurance Commissioner** Address: West Virginia Offices of the Insurance Commissioner P.O. Box 50540 Charleston, West Virginia 25305-0540 Phone: (304) 558-3354 or 1-888-TRY-WVIC website: https://www.wvinsurance.gov/Consumer_Services and https://www.wvinsurance.gov/HealthPolicy

NOTICE OF PATIENT PROTECTIONS

Latitude AI LLC Welfare Benefit Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our 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, contact the People Operations Benefits Team at 2545 Railroad Street, Pittsburgh, Pennsylvania 15222, (412) 709-6992 or benefits@lat.ai.

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

You do not need prior authorization from Latitude AI, LLC Welfare Benefit Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the People Operations Benefits Team at 2545 Railroad Street, Pittsburgh, Pennsylvania 15222, (412) 709-6992 or benefits@lat.ai.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

LATITUDE AI LLC EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within ***60 days*** after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact: the People Operations Benefits Team at benefits@lat.ai or 412-709-6992

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

NOTICE OF PRIVACY PRACTICES

Latitude AI, LLC
2545 Railroad Street
Pittsburgh, Pennsylvania 15222
(412) 709-6992

Privacy Official:

People Operations, Benefits Team
2545 Railroad Street
Pittsburgh, Pennsylvania 15222
(412) 709-6992
benefits@lat.ai

Effective Date: 02/01/2023

Your Information. Your Rights. Our Responsibilities.
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.**

Your Rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services

- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at:

  People Operations, Benefits Team
  2545 Railroad Street, Pittsburgh, Pennsylvania 15222
  (412) 709-6992
  benefits@lat.ai

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and share your information to run our organization and contact you when necessary.

- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

LATITUDE AI LLC IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

This notice is provided to you on behalf of:

Latitude AI LLC*

* This notice pertains only to healthcare coverage provided under the plan.

The Plan's Duty to Safeguard Your Protected Health Information
Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Latitude AI LLC that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information
The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
- **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.
- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
    - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Latitude AI LLC) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
    - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
    - **Required by Law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
    - **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
    - **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
    - **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
    - **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
    - **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
    - **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis.
Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Bri Mitcheson
People Operations Manager II, Benefits
412-709-6992

Effective Date

The effective date of this notice is: November 1, 2023

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) DISCLOSURE

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the Latitude AI, LLC Welfare Benefit Plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (412) 709-6992.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) DISCLOSURE

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

GENERAL FMLA NOTICE

EMPLOYEE RIGHTS

UNDER THE FAMILY AND MEDICAL LEAVE ACT

The United States Department of Labor Wage and Hour Division

Leave Entitlements
Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections
While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements
An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities
Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement
Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:
1-866-4-USWAGE (1-866-487-9243) TTY: 1-877-889-5627
www.dol.gov/whd

USERRA NOTICE

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right To Be Free From Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for
- service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm.*

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm.*

Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service,
1-866-487-2365.

IMPORTANT NOTICE FROM LATITUDE AI LLC ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Latitude AI LLC and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Latitude AI LLC has determined that the prescription drug coverage offered by the Latitude AI LLC Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Latitude AI LLC Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Latitude AI LLC Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Latitude AI LLC Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Latitude AI LLC prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information, or call 412-709-6992. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Latitude AI LLC changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

GENERAL COBRA NOTICE

General Notice of COBRA Continuation Coverage Rights

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended: Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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**.

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.
If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under 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/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 your Plan informed of address changes.

To protect your family's rights, let the Plan 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 Plan Administrator.

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

People Operations Benefits Team
2545 Railroad St. Suite 400
Pittsburgh, PA 15222
412-709-6992
benefits@lat.ai

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

Latitude AI LLC Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our 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, contact the plan administrator at 412-709-6992.

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

You do not need prior authorization from Latitude AI LLC Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Latitude AI LLC Employee Health Care Plan at:

People Operations Benefits Team
2545 Railroad Street, Suite 400
Pittsburgh, PA 1522
412-709-6992
benefits@lat.ai

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Latitude AI LLC Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Latitude AI LLC Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

PPO	In-Network	Out-of-Network
Individual Deductible	$0	$1,000
Family Deductible	$0	$2,000
Coinsurance	0%	40%

HSA	In-Network	Out-of-Network
Individual Deductible	$2,000	$4,000
Family Deductible	$4,000	$4,000
Coinsurance	0%	20%

HMO	In-Network	Out-of-Network
Individual Deductible	$0	No Coverage Available
Family Deductible	$0	No Coverage Available
Coinsurance	0%	No Coverage Available

If you would like more information on WHCRA benefits, please refer to your or contact your Plan Administrator at:

People Operations Benefits Team
2545 Railroad Street, Suite 400
Pittsburgh, PA 15222
412-709-6992
benefits@lat.ai

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, 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. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MICHELLE'S LAW NOTICE

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the People Operations Benefits Team at benefits@lat.ai or 412-709-6992.

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

Latitude AI LLC Wellness Program is a voluntary wellness program available to . The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

Details about the wellness program, including criteria and incentives, can be found on Confluence or by reaching out to the Latitude AI LLC Benefits Team at benefits@lat.ai.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Latitude AI LLC Leave Team at leaveteam@lat.ai.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Latitude AI LLC may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law.
Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are the Latitude AI LLC Benefits Team in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Bri Mitcheson at 412-709-6992.

ILLINOIS DOL EMPLOYER EHB LIST NOTICE

Employer Name:	**Latitude AI LLC**
Employer State of Situs:	**Pennsylvania**
Name of Issuer:	**Cigna**
Plan Marketing Name:	**HSA, OAP**
Plan Year:	**2024**

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2023 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 77, 84	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 18, 53	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 55	Yes

4	**Durable Medical Equipment**	**Ambulatory**	**Pg. 7, 28, 34, 37**	**Yes**

5	Hospice	Ambulatory	Pg. 24, 35, 36, 78, 80	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 28, 39	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 29	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 30, 32, 39, 78	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 24	Yes
10	Prosthetics/Orthotics	Ambulatory	Pg. 40	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 27, 39	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 34	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pgs. 77, 84	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 21, 33, 74	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 55	No
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 40, 55, 65	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 40, 55, 65	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 20-22, 24-35, 37, 39, 40	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 53, 78, 83, 84	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 28, 40, 41	Yes
21	Diagnostic Services	Laboratory services	Pgs. 20, 33, 37, 40, 54, 78	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. PDL	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pg. 7, 23, 24, 29, 30, 36, 40, 41	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. PDL	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pg. 24, 29, 30, 31, 32, 36, 37, 40, 41, 77, 78	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 30	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. PDL	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	Pg. 77	Yes

29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 77	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 26, 32, 65, 77	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 24, 42	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 17, 33	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 27	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 29, 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 42, 82	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 20, 33	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 39	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 20, 33	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 20, 34, 38	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 27, 39	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 23, 40, 75	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 40, 77	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

TABLE OF CONTENTS - PLAN DOCUMENTS

If you have any questions or would like to request a hard copy of any of these plan documents to be mailed to you, please reach out to the Latitude AI Benefits Team at benefits@lat.ai.

Latitude AI, LLC

OPEN ACCESS PLUS MEDICAL
BENEFITS

EFFECTIVE DATE: March 1, 2023

CN004
3344486

This document printed in April, 2023 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Latitude AI, LLC

GROUP POLICY(S) — COVERAGE
3344486 - OAP OPEN ACCESS PLUS MEDICAL BENEFITS

EFFECTIVE DATE: March 1, 2023

THIS CERTIFICATE CONTAINS A PREFERRED PROVIDER ARRANGEMENT FOR MEDICAL BENEFITS.

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

Geneva Cambell Brown, Corporate Secretary

Julia M. Huggins, President

Explanation of Terms

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

The Schedule

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

Special Plan Provisions

When you select a Participating Provider, 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-SPP1 04-10
V1

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HC-SPP63 01-20

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 insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the

treatment program remains appropriate to the patient's needs.

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

HC-SPP2 04-10
V1

Additional Programs

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

HC-SPP3 04-10
V1

Care Management and Care Coordination Services

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

HC-SPP27 06-15
V1

Important Notices

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care 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 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 your plan and Prescription Drug Products included on the Prescription Drug List. 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 may also, conduct business with various pharmaceutical manufacturers separate and apart from this plan’s Medical Pharmaceutical and Prescription Drug Product 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 and Prescription Drug Products. 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 and Prescription Drug Product 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.

If Cigna determines that a Pharmacy, pharmaceutical manufacturer or other third party is or has waived, reduced, or forgiven any portion of the charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Prescription Drug Product without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of plan benefits in connection with the Prescription Drug Product, 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 Pharmacy, pharmaceutical manufacturer or other third party represents that you remain responsible for any amounts that your 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.

For example, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a Prescription Drug Product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.

HC-IMP260 08-19
V7

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, including sex stereotypes and gender identity. Coverage for medically necessary health services is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. Cigna will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. Cigna will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

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 01-20
V4

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

Important Notices

PLEASE READ THIS NOTICE CAREFULLY; IT CONTAINS IMPORTANT INFORMATION YOU SHOULD KNOW BEFORE YOU ELECT COVERAGE.

THIS MATERIAL IS NOT INTENDED TO SUPPLEMENT OR REPLACE ANY PLAN DOCUMENTS APPLICABLE ONCE YOU DO ELECT COVERAGE. IF COVERAGE IS ELECTED, ALL OF YOUR RIGHTS AND OBLIGATIONS UNDER YOUR PLAN SHALL BE GOVERNED BY THE APPLICABLE PLAN DOCUMENTS.

Listing of Information Available Upon Request

The following information may be available to you upon request to Customer Service:

- A list of the Provider Organization's officers and directors including their business addresses and official positions.
- A copy of the Provider Organization's confidentiality procedures.

- A description of the credentialing process for providers.
- A list of the participating providers affiliated with participating Hospitals.
- Whether a specifically identified drug is included or excluded from coverage.
- A description of the process by which a health care provider can prescribe specific drugs used for an off-label purpose, biologicals and medications not included in the Prescription Drug List for the prescription drugs or biologicals, when the Prescription Drug List's equivalent has been ineffective in the treatment of the enrollee's disease, or if the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee.
- A description of the procedures followed by Cigna Health and Life Insurance Company (Cigna) to make decisions about the experimental nature of individual drugs, medical devices or treatments.
- A summary of the methodologies used by Cigna to reimburse for health care services.
- A description of procedures used in the Provider organization's quality assurance program.

HC-IMP62 04-11
V1

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

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

WARNING: Any person who knowingly and with intent to defraud any insurance company or another 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 fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

HC-CLM25 01-20
V22

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 30 hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within 3 months after your insurance ceased.

Eligibility for Dependent Insurance

You will become eligible for Dependent Insurance on the later of:

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

Waiting Period

None.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

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

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

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

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

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns

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

HC-ELG224 M 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 medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

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, if you choose.

Continuity Of Care

A new enrollee may continue an ongoing course of treatment with a nonparticipating health care provider, or a covered person with a participating provider when the plan initiates termination of the provider's contract, except for cause including fraud, breach of contract, criminal activity or posing a danger to health or safety. Treatment may continue, at the covered person's option, for a transitional period of up to 60 days from enrollment from the date the covered person was notified by the plan of the termination, under the same terms and conditions as those applicable for participating providers. If considered clinically appropriate by the plan, the transitional period may be extended. When the covered person is in the second or third trimester of pregnancy, the transitional period shall extend through postpartum care related to the delivery.

HC-IMP1 04-10

V3

Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

If 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 Covered Expenses that an insured person is required to pay under the plan in addition to the Deductible, if any.

Copayments/Deductibles

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

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

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

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

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

- Coinsurance.
- Plan Deductible.

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

- Non-compliance penalties.
- Any copayments and/or benefit deductibles.
- Provider charges in excess of the Maximum Reimbursable Charge.

Accumulation of Plan Out-of-Pocket Maximums

Out-of-Pocket Maximums do not cross-accumulate (that is, In-Network will accumulate to In-Network and Out-of-Network will accumulate 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.

Open Access Plus Medical Benefits
The Schedule

Multiple Surgical Reduction

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

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

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

Co-Surgeon

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

Out-of-Network 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 other facility as required by Pennsylvania law, 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). 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	100%	60% 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.	Not Applicable	110%
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.		
Calendar Year Deductible Individual Family Maximum Family Maximum Calculation **Individual Calculation:** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.	Not Applicable Not Applicable	$1,000 per person $2,000 per family

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Out-of-Pocket Maximum		
Individual	$1,250 per person	$10,000 per person
Family Maximum	$2,500 per family	$20,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		
Combined Medical/Pharmacy Out-of-Pocket Maximum		
Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery drugs	Yes	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	Yes	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office Visit	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
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	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician	$25 per visit copay, then 100%	Plan deductible, then 60%
Second Opinion Consultations (provided on a voluntary basis)		
Primary Care Physician's Office Visit	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
Allergy Treatment/Injections		
Primary Care Physician's Office Visit	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
Allergy Serum (dispensed by the Physician in the office)		
Primary Care Physician	100%	Plan deductible, then 60%
Specialty Care Physician	100%	Plan deductible, then 60%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Virtual Care		
Dedicated Virtual Providers		
Services available through contracted virtual providers as medically appropriate.		
Urgent Virtual Care Services	$10 per visit copay, then 100%	In-Network coverage only
Dedicated Virtual Primary Care Physician	$10 per visit copay, then 100%	In-Network coverage only
Dedicated Virtual Specialty Care Physician	$25 per visit copay, then 100%	In-Network coverage only
Note: Dedicated Virtual Providers may deliver services that are payable under other benefits (e.g., Preventive Care, Primary Care Physician, Behavioral; Dermatology/Specialty Care Physician).		
Lab services supporting a virtual visit must be obtained through dedicated labs.		
Virtual Physician Services		
Services available through Physicians as medically appropriate.		
Note: Preventive services covered at the preventive level.		
Primary Care Physician's Office Visit	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Preventive Care		
Routine Preventive Care - all ages		
Primary Care Physician's Office Visit	100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	100%	Plan deductible, then 60%
Immunizations (for children through age 20)		
Primary Care Physician's Office Visit	100%	60%
Specialty Care Physician's Office Visit	100%	60%
Immunizations (for ages 21 and over)		
Primary Care Physician's Office Visit	100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	100%	Plan deductible, then 60%
Mammograms, PSA, PAP Smear		
Preventive Care Related Services (i.e. "routine" services)	100%	Subject to the plan's x-ray benefit & lab benefit; based on place of service. Plan deductible does not apply to PAP Smear.
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
Inpatient Hospital - Facility Services	100%	Plan deductible, then 60%
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	100%	Plan deductible, then 60%
Inpatient Hospital Physician's Visits/Consultations	100%	Plan deductible, then 60%
Inpatient Professional Services	100%	Plan deductible, then 60%
Surgeon		
Radiologist, Pathologist, Anesthesiologist		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Professional Services Surgeon Radiologist, Pathologist, Anesthesiologist	100%	Plan deductible, then 60%
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.	$25 per visit copay, then 100%	$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 The scan copay applies per type of scan per day	$150 per scan copay, then $25 per visit copay, then 100%	$150 per scan copay, then $25 per visit copay, 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.	$175 per visit copay (waived if admitted), then 100%	$175 per visit copay (waived if admitted), then 100%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER visit The scan copay applies per type of scan per day	$150 per scan copay, then $175 per visit copay (waived if admitted), then 100%	$150 per scan copay, then $175 per visit copay (waived if admitted), then 100%
Ambulance	100%	100%
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 100 days combined	100%	Plan deductible, then 60%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Laboratory Services		
Primary Care Physician's Office Visit	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
Outpatient Hospital Facility	100%	Plan deductible, then 60%
Independent Lab Facility	100%	Plan deductible, then 60%
Radiology Services		
Primary Care Physician's Office Visit	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
Outpatient Hospital Facility	100%	Plan deductible, then 60%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
The scan copay applies per type of scan per day		
Primary Care Physician's Office Visit	$150 per scan copay, then $10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$150 per scan copay, then $25 per visit copay, then 100%	Plan deductible, then 60%
Inpatient Facility	100%	Plan deductible, then 60%
Outpatient Facility	$150 per scan copay, then 100%	Plan deductible, then 60%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Therapy Services Calendar Year Maximum: 60 days for all therapies combined (The limit is not applicable to mental health conditions.) **Note:** The Outpatient Therapy Services maximum does not apply to the treatment of autism. Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy		
Primary Care Physician's Office Visit	$10 per visit copay*, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay*, then 100% ***Note:** Outpatient Therapy Services copay applies, regardless of place of service, including the home.	Plan deductible, then 60%
Outpatient Cardiac Rehabilitation Calendar Year Maximum: 36 days		
Primary Care Physician's Office Visit	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
Chiropractic Care Calendar Year Maximum: 60 days		
Primary Care Physician's Office Visit	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Acupuncture Self-referred, Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis, limited to a 12 day maximum per person per Contract Year		
Primary Care Physician's Office Visit	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
Home Health Care Services Calendar Year Maximum: 60 days (includes outpatient private nursing when approved as Medically Necessary) (The limit is not applicable to Mental Health and Substance Use Disorder conditions.)	100%	Plan deductible, then 60%
Hospice		
Inpatient Services	100%	Plan deductible, then 60%
Outpatient Services (same coinsurance level as Home Health Care Services)	100%	Plan deductible, then 60%
Bereavement Counseling Services provided as part of Hospice Care		
Inpatient	100%	Plan deductible, then 60%
Outpatient	100%	Plan deductible, then 60%
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Medical Pharmaceuticals		
Physician's Office	100%	Plan deductible, then 60%
Home Care	100%	Plan deductible, then 60%
Inpatient Facility	100%	Plan deductible, then 60%
Outpatient Facility	100%	Plan deductible, then 60%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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	100%	In-Network coverage only
Outpatient Facility	100%	In-Network coverage only
Inpatient Professional Services	100%	In-Network coverage only
Outpatient Professional Services	100%	In-Network coverage only
Travel Maximum: $10,000 per episode of gene therapy	100% (available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy)	In-Network coverage only

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	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100%	Plan deductible, then 60%
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	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
Delivery - Facility (Inpatient Hospital, Birthing Center)	100%	Plan deductible, then 60%
Abortion		
Includes elective and non-elective procedures		
Primary Care Physician's Office Visit	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
Inpatient Facility	100%	Plan deductible, then 60%
Outpatient Facility	100%	Plan deductible, then 60%
Inpatient Professional Services	100%	Plan deductible, then 60%
Outpatient Professional Services	100%	Plan deductible, then 60%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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 60%
Specialty Care Physician	100%	Plan deductible, then 60%
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)		
Primary Care Physician's Office Visit	100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	100%	Plan deductible, then 60%
Inpatient Facility	100%	Plan deductible, then 60%
Outpatient Facility	100%	Plan deductible, then 60%
Inpatient Professional Services	100%	Plan deductible, then 60%
Outpatient Professional Services	100%	Plan deductible, then 60%
Men's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling		
Primary Care Physician	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician	$25 per visit copay, then 100%	Plan deductible, then 60%
Surgical Sterilization Procedures for Vasectomy (excludes reversals)		
Primary Care Physician's Office Visit	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
Inpatient Facility	100%	Plan deductible, then 60%
Outpatient Facility	100%	Plan deductible, then 60%
Inpatient Professional Services	100%	Plan deductible, then 60%
Outpatient Professional Services	100%	Plan deductible, then 60%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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). • Artificial Insemination, In-vitro, GIFT, ZIFT, etc.		
Physician's Office Visit (Lab and Radiology Tests, Counseling)		
Primary Care Physician	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician	$25 per visit copay, then 100%	Plan deductible, then 60%
Inpatient Facility	100%	Plan deductible, then 60%
Outpatient Facility	100%	Plan deductible, then 60%
Inpatient Professional Services	100%	Plan deductible, then 60%
Outpatient Professional Services	100%	Plan deductible, then 60%
Lifetime Maximum: Unlimited Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).		
Transplant Services and Related Specialty Care Includes all medically appropriate, non-experimental transplants		
Primary Care Physician's Office Visit	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
Inpatient Facility	100% at LifeSOURCE center, otherwise 100%	Plan deductible, then 60%
Inpatient Professional Services	100% at LifeSOURCE center, otherwise 100%	Plan deductible, then 60%
Lifetime Travel Maximum: Unlimited	100% (only available when using LifeSOURCE facility)	In-Network coverage only
Durable Medical Equipment Calendar Year Maximum: Unlimited	100%	Plan deductible, then 60%
External Prosthetic Appliances Calendar Year Maximum: Unlimited	100%	Plan deductible, then 60%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Diabetic Equipment Calendar Year Maximum: Unlimited	100%	Plan deductible, then 60%
Nutritional Counseling Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of diabetes and/or to mental health and substance use disorder conditions.		
Primary Care Physician's Office Visit	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
Inpatient Facility	100%	Plan deductible, then 60%
Outpatient Facility	100%	Plan deductible, then 60%
Inpatient Professional Services	100%	Plan deductible, then 60%
Outpatient Professional Services	100%	Plan deductible, then 60%
Enteral Nutrition (Nutritional Formulas)	100%	60%
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	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
Inpatient Facility	100%	Plan deductible, then 60%
Outpatient Facility	100%	Plan deductible, then 60%
Inpatient Professional Services	100%	Plan deductible, then 60%
Outpatient Professional Services	100%	Plan deductible, then 60%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to teeth.		
Primary Care Physician's Office Visit	$10 per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	$25 per visit copay, then 100%	Plan deductible, then 60%
Inpatient Facility	100%	Plan deductible, then 60%
Outpatient Facility	100%	Plan deductible, then 60%
Inpatient Professional Services	100%	Plan deductible, then 60%
Outpatient Professional Services	100%	Plan deductible, then 60%
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.
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	100%	Plan deductible, then 60%
Outpatient		
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited	$25 per visit copay, then 100%	Plan deductible, then 60%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc. Calendar Year Maximum: Unlimited	100%	Plan deductible, then 60%

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	100%	Plan deductible, then 60%
Outpatient		
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited	$25 per visit copay, then 100%	Plan deductible, then 60%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc. Calendar Year Maximum: Unlimited	100%	Plan deductible, then 60%

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, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will be reduced by 50% for Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission.

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

- Hospital charges for Room and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

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

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

Outpatient Certification Requirements – Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient 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 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 be reduced by 50% for charges made for any outpatient procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

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

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

Outpatient Procedures

Including, but not limited to:

- 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 policy.

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

- inpatient Hospital services, except for 48/96 hour maternity stays.
- inpatient services at any participating Other Health Care Facility.
- residential treatment.

- non-emergency Ambulance.
- certain Medical Pharmaceuticals.
- radiation therapy.
- transplant services.

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 for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital, subject to the limits as shown in The Schedule.
- charges for inpatient Room and Board and other Necessary Services and Supplies made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility as shown in The Schedule.
- charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
- charges for outpatient medical care and treatment received at a Hospital.
- charges for outpatient medical care and treatment received at a Free-Standing Surgical Facility.
- charges for Emergency Services.
- charges for Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse for professional nursing service.
- charges made for anesthetics, including, but not limited to supplies and their administration.
- charges for diagnostic x-ray.
- charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.
- charges for chemotherapy.
- charges for blood transfusions.
- charges for oxygen and other gases and their administration.
- charges made for Medically Necessary foot care for diabetes, peripheral neuropathies and peripheral vascular disease.
- charges made for or in connection with mammograms, including digital breast tomosynthesis, for breast cancer screening and diagnosis, not to exceed: a baseline mammogram annually for women age 40 and over; and a mammogram upon a Physician's recommendation for women under age 40.
- charges for an annual gynecological exam, including a pelvic exam and a routine pap smear. No dollar limit or Deductible may be applied to routine pap smears.
- charges for colorectal cancer screening for non-symptomatic persons who are 50 years of age or older shall include, but not be limited to: an annual fecal occult blood test; a sigmoidoscopy, a screening barium enema or a test consistent with approved medical standards and practices to detect colon cancer, at least once every 5 years; and a colonoscopy at least once every 10 years.

  Coverage for symptomatic persons shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating Physician. "Symptomatic person" means an individual who experiences a change in bowel habits, rectal bleeding or persistent stomach cramps, weight loss or abdominal pain.

  Coverage for a non-symptomatic person at high or increased risk for colorectal cancer who is under 50 years of age shall include a colonoscopy or any combination of colorectal cancer screening tests in accordance with the American Cancer Society guidelines on screening for colorectal cancer published as of January 1, 2008. "Non-symptomatic person at high or increased risk" means an individual who poses a higher than average risk for colorectal cancer.
- charges made for screening prostate-specific antigen (PSA) testing.
- 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 and vasectomies.
- charges for the following preventive care services as defined by recommendations from the following:
  - the U.S. Preventive Services Task Force (A and B recommendations);
  - the Advisory Committee on Immunization Practices (ACIP) for immunizations;
  - the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;
  - the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
  - with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.

  Detailed information is available at www.healthcare.gov. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.
- charges for childhood immunizations, including the immunizing agents and Medically Necessary booster doses. Immunizations provided in accordance with Advisory Committee on Immunization Practices (ACIP) standards are covered for any insured person under age 21 and are exempt from Deductibles or dollar limits.
- charges made for surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.
- charges made for acupuncture services involving the stimulation of specific anatomical locations on the skin through the penetration of fine needles, for the purpose of relieving pain or treating disease as medically.

Virtual Care

Dedicated Virtual Providers

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

Virtual Physician Services

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

Behavioral consultations and services via secure telecommunications technologies that shall include video capability, including telephones and internet, when delivered through a behavioral provider.

- charges made for treatment of Serious Mental Illness. Such Covered Expenses will be payable the same as for other illness.
- charges for at least 48 hours of inpatient care following a mastectomy. A longer period of time will be covered if the treating Physician determines it is Medically Necessary. Home health care services will also be provided if the treating Physician deems these services Medically Necessary.
- charges made for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders for covered persons under age 21.

  "Autism spectrum disorders" means any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.
- charges for Hospital Confinement of a mother and her newborn child for 48 hours following a vaginal delivery, or for 96 hours following a cesarean section. The mother may request an earlier discharge, if after consulting with her Physician, it is determined that less time is needed for recovery.
- charges for services provided to the newborn will be absorbed within the mother's cost-sharing limitation. A separate deductible does not apply to the child until the child is separately enrolled as a dependent after the first 31 days of the child's life.
- charges made for one postpartum home health care visit, within 48 hours following discharge from the Hospital of the mother and newborn, provided that discharge occurs prior to:
  - 48 hours for normal vaginal delivery; or
  - 96 hours for a cesarean section.

  Postpartum home health care visits will be covered for women if determined to be Medically Necessary. No Copayment, Coinsurance or Deductible will apply to postpartum home health care services.
- the following benefits will apply to insulin-dependent, and non-insulin-dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:
  - charges for Durable Medical Equipment, including glucometers; blood glucose monitors; insulin pumps; infusion devices and related accessories, including those adaptable for the legally blind; podiatric appliances; and

glucagon emergency kits. A special maximum will not apply.

- charges for training by a Physician with expertise in diabetes management, but limited to the following:
  - Medically Necessary visits when diabetes is diagnosed;
  - Medically Necessary visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
  - visits when reeducation or refresher training is prescribed by the Physician; and
  - medical nutrition therapy related to diabetes management.

Nutritional Counseling

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

Enteral Nutrition

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

Coverage includes Medically Necessary nutritional supplements for the treatment of inborn errors of metabolism (e.g. disorders of amino acid or organic acid metabolism).

Benefits for nutritional support (formulas) as Medically Necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a Physician shall be exempt from Deductible.

Internal Prosthetic/Medical Appliances

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

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V1

Home Health Care Services

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

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

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

Covered services include:

- skilled nursing services provided by a Registered Nurse (RN); Licensed Practical Nurse (LPN); Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse (APRN).
- services provided by health care providers such as a physical therapist; occupational therapist or speech therapist.
- services of a home health aide when provided in direct support of those Nurses and health care providers.
- necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.

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

The following are excluded from coverage:

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

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

HC-COV1007 01-21

Hospice Care Services

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

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

HC-COV882 01-20

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.

Inpatient Detoxification Services

Inpatient detoxification for the diagnosis and treatment of abuse of or addiction to alcohol and/or drugs, or alcohol in combination with drugs shall be provided either in a Hospital or in an inpatient non-Hospital facility which is licensed as an alcoholism and/or drug addiction treatment program and meets the requirements of Pennsylvania law. Before an insured may qualify to receive benefits under this section, a Physician or Psychologist must certify the insured as a person suffering from alcohol or drug abuse or dependency and must refer the insured for the appropriate treatment. The following services are covered under inpatient detoxification:

- lodging and dietary services;
- Physician, Psychologist, Nurse, certified addictions counselor and trained staff services;
- diagnostic x-ray;
- psychiatric, psychological and medical laboratory testing; and
- drugs, medicines, equipment use and supplies.

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.

HC-COV137 04-10
V3

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.

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

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

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

HC-COV1008 01-21

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription 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;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- non-foot orthoses primarily used for cosmetic rather than functional reasons; and

- non-foot orthoses primarily for improved athletic performance or sports participation.

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

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

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

Coverage for replacement is limited as follows:

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

The following are specifically excluded external prosthetic appliances and devices:

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

HC-COV1009 01-21

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

  Infertility is defined as:

  - the inability of opposite-sex partners to achieve conception after at least 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:

  - 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-COV824 03-19

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

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

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

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

Therapy services that are not covered include:

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

Coverage is administered according to the following:

- multiple therapy services provided on the same day constitute one day of service for each therapy type.
- a separate Copayment applies to the services provided by each provider for each therapy type per day.

HC-COV1012 01-21

Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement 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.

Cigna does not deny eligibility or continued eligibility for enrollment or to renew coverage under this plan for these services.

HC-COV1080 01-21

Transplant Services and Related Specialty Care

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. Implantation procedures for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO), ventricular assist device (VAD), and intra-aortic balloon pump (IABP) are also covered.

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

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

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

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

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

Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant; the transplant recipient's plan would cover all donor costs.

HC-COV1013 01-21

Medical Pharmaceuticals

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

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. 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.

The following diabetic supplies are also covered under the plan's medical benefit: alcohol pads, swabs, wipes, Glucagon/Glucagen, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips, insulin, injection aids, pre-filled insulin pens and cartridges, pharmacological agents for controlling blood sugar.

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

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

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

HC-COV1039 01-21

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.

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Clinical Trials

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. Cigna does not deny eligibility for enrollment in its plans for any member who participates in a Clinical Trial. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

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

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

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

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

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

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

Examples of routine patient care costs and services include:

- radiological services;

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

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

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

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Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, for a reason other than failure of the person to pay premium or if the policy is replaced by similar group insurance within 31 days, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by Cigna only to a person who:

- resides in a state that requires offering a conversion policy,
- is Entitled to Convert, and
- applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled to Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased but only if:

- you are not eligible for other individual insurance coverage on a guaranteed issue basis.
- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

If you retire, you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for other individual insurance coverage on a guaranteed issue basis, is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other

plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy

If you reside in a state that requires the offering of a conversion policy, the Converted Policy will be one of Cigna's current conversion policy offerings available in the state where you reside, as determined based upon Cigna's rules.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are Entitled to Convert it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

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Prescription Drug Benefits
The Schedule

For You and Your Dependents

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

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

Coinsurance

The term Coinsurance means the percentage of charges for covered Prescription Drug Products that you or your Dependent are required to pay under this plan.

Copayments (Copay)

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

Oral Chemotherapy Medication

Prescription self-injectable and oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered at Network Pharmacies at 100% with no deductible and if applicable at non-Network Pharmacies, on a basis no less favorable than the out of network medical cost share for injectable/IV chemotherapy.

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Patient Assurance Program Your plan offers additional discounts for certain covered Prescription Drug Products that are dispensed by a retail or home delivery Network Pharmacy included in what is known as the "Patient Assurance Program". As may be described elsewhere in this plan, from time to time Cigna may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your Out-of-Pocket Expenses for certain covered Prescription Drug Products for which Cigna directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna for certain covered Prescription Drug Products included in the Patient Assurance Program is applied or credited to a portion of your Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drug Products as set forth in The Schedule may be reduced in order for Patient Assurance Program discounts earned by Cigna to be applied or credited to the Copayment or Coinsurance, if any, as described above. For example, certain insulin product(s) covered under the Prescription Drug Benefit for which Cigna directly or indirectly earns a discount in connection with the Patient Assurance Program shall result in a credit toward some or all of your Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in The Schedule, for the insulin product. In addition, the covered insulin products eligible for Patient Assurance Program discounts shall not be subject to the Deductible, if any. Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum. Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum. Please note that the Patient Assurance Program discounts that Cigna may earn for Prescription Drug Products, and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any rebates or other payments that Cigna may earn from a pharmaceutical manufacturer for the same or other Prescription Drug Products. Except as may be noted elsewhere in this plan, you are not entitled to the benefit of those rebates or other payments earned by Cigna because they are unrelated to the Patient Assurance Program. Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drug Products included in the Patient Assurance Program and/or your Copayment or Coinsurance, if any for those eligible Prescription Drug Products, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to Cigna in connection with the Patient Assurance Program. More information about the Patient Assurance Program including the Prescription Drug Products included in the program, is available at the website shown on your ID card or by calling member services at the telephone number on your ID card.		
Out-of-Pocket Maximum		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Maintenance Drug Products Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Pharmacy or home delivery Pharmacy.		

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Certain Preventive Care Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required.		
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy**
Certain Specialty Prescription Drug Products are only covered when dispensed by a home delivery Pharmacy.		
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $10 Copay	40%
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $40 Copay	40%
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $75 Copay	40%
Tier 4 Self-Administered Injectable Specialty Prescription Drug Products	No charge after $95 Copay	40%
Prescription Drug Products at Retail Designated Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Designated Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Designated Pharmacy**
Certain Specialty Prescription Drug Products are only covered when dispensed by a home delivery Pharmacy.		
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill.		
Note: In this context, a retail Designated Pharmacy is a retail Network Pharmacy that has contracted with Cigna for dispensing of covered Prescription Drug Products, including Maintenance Drug Products, in 90-day supplies per Prescription Order or Refill.		
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $20 Copay	40%

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $80 Copay	40%
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $150 Copay	40%
Tier 4 Self-Administered Injectable Specialty Prescription Drug Products	Specialty Prescription Drug Products are limited to up to a consecutive 30 day supply per Prescription Order or Refill.	Specialty Prescription Drug Products are limited to up to a consecutive 30 day supply per Prescription Order or Refill.
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy**
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $20 Copay	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $80 Copay	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $150 Copay	In-network coverage only
Tier 4 Self-Administered Injectable Specialty Prescription Drug Products	No charge after $190 Copay	In-network coverage only

Prescription Drug Benefits

Covered Expenses

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

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

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

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

Prescription Drug List Management

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

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

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Limitations

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

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

for payment of only a Generic Drug Copayment and/or Coinsurance, after satisfying your Deductible, if any.

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

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

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

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

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the diagnosis and the Prescription Drug Product. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

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

Step Therapy

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

Supply Limits

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

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

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

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products.

Designated Pharmacies

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

Synchronization of Prescription Drug Refills

Prescription drug coverage shall provide for the synchronization of prescription drug refills no more than 3 times per year with the exception of unit-of-use packaging that

indicates medication synchronization is not possible or controlled substances classified in Schedule II of The Controlled Substance, Drug, Device and Cosmetic Act.

Prorated daily cost-sharing rate shall apply for the synchronized medication but not apply to dispensing fees. All dispensing fees shall be based on the number of prescriptions filled or refilled.

Synchronization means the coordination of medication refills for a patient taking two or more medications for one or more chronic conditions such that the patient's medications are refilled on the same schedule for a given time period.

New Prescription Drug Products

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

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Your Payments

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

Copayment

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

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

Payments at Non-Network Pharmacies

Any reimbursement due to you under this plan for a covered Prescription Drug Product dispensed by a non-Network Pharmacy may be determined by applying the Deductible, if any, and/or non-Network Pharmacy Coinsurance amount set forth in The Schedule to the average wholesale price (or "AWP"), or other benchmark price Cigna applies, for a Prescription Drug Product dispensed by a non-Network Pharmacy. Your reimbursement, if any, for a covered Prescription Drug Product dispensed by a non-Network Pharmacy will never exceed the average wholesale price (or other benchmark price applied by Cigna) for the Prescription Drug Product.

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

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

The amount you or your Dependent pays for any excluded Prescription Drug Product or other product or service will not be included in calculating any applicable plan Out-of-Pocket Maximum. You are responsible for paying 100% of the cost (the amount the Pharmacy charges you) for any excluded Prescription Drug Product or other product.

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Exclusions

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

- coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum

set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.

- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products dispensed outside the jurisdiction of the United States, except as required for emergency or Urgent Care treatment.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- medications used for cosmetic purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth and fade cream products.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.
- Prescription Drug Products used for the treatment of male or female sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, hypoactive sexual desire disorder and decreased libido.
- any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).
- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
- medications used for travel prophylaxis, immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions unless specifically identified on the Prescription Drug List.
- smoking cessation medications except those required by federal law to be covered as Preventive Care Medications.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- medications that are experimental, investigational or unproven as described under the "General Exclusion and Limitations" section of your plan's certificate.

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Reimbursement/Filing a Claim

Retail Pharmacy

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

applicable copay and the Prescription Drug Charge for the Prescription Drug Product.

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

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- 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 your 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 Cigna. 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. Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.
- 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 plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to 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: macromastia or gynecomastia surgeries; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- 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 six months of an accident.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long-term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Care Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Care Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- 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 corrective lenses, or the first set of eyeglass lenses and frames and associated services for treatment of keratoconus or following cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- all non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.

- routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services 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.
- enteral feedings, supplies and specially formulated medical foods that are prescribed and non-prescribed, except for infant formula needed for the treatment of inborn errors of metabolism.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- massage therapy.

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 plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.

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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.

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

The amount of charges considered for payment under the Plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

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

Order of Benefit Determination Rules

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

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child; and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

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

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

Effect on the Benefits of This Plan

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

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

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

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

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

Recovery of Excess Benefits

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

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

Right to Receive and Release Information

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

Coordination of Benefits with Medicare

If you, your spouse, or your Dependent are covered under this Plan and qualify for Medicare, federal law determines which Plan is the primary payer and which is the secondary payer. The primary payer always determines covered benefits first, without considering what any other coverage will pay. The secondary payer determines its coverage only after the Primary Plan has completed its determination.

When Medicare is the Primary Payer

Medicare will be the primary payer and this Plan will be the secondary payer, even if you don't elect to enroll in Medicare or you receive services from a provider who does not accept Medicare payments, in the following situations:

- COBRA or State Continuation: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to COBRA or state continuation of coverage.
- Retirement or Termination of Employment: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to your retirement or termination of employment.
- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has fewer than 100 employees.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has fewer than 20 employees.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan will be the primary payer for

the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

When This Plan is the Primary Payer

This Plan will be the primary payer and Medicare will be the secondary payer in the following situations:

- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has 100 or more employees.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has 20 or more employees.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan is the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

Domestic Partners

Under federal law, when Medicare coverage is due to age, Medicare is always the primary payer and this Plan is the secondary payer for a person covered under this Plan as a Domestic Partner. However, when Medicare coverage is due to disability, the Disability payer explanations above will apply.

IMPORTANT: If you, your spouse, or your Dependent do not elect to enroll in Medicare Parts A and/or B when first eligible, or you receive services from a provider who does not accept Medicare payments, this Plan will calculate payment based on what should have been paid by Medicare as the primary payer if the person had been enrolled or had received services from a provider who accepts Medicare payments. A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective.

Failure to Enroll in Medicare

If you, your spouse, or your Dependent do not enroll in Medicare Parts A and/or B during the person's initial Medicare enrollment period, or the person opts out of coverage, the person may be subject to Medicare late enrollment penalties, which can cause a delay in coverage and result in higher Medicare premiums when the person does enroll. It can also result in a reduction in coverage under Medicare Parts A and B. If you are planning to retire or terminate employment and you will be eligible for COBRA, state Continuation, or retiree coverage under this Plan, you should enroll in Medicare before you terminate employment to avoid penalties and to receive the maximum coverage under Medicare. Please consult Medicare or the Social Security Administration for more information.

Assistance with Medicare Questions

For more information on Medicare's rules and regulations, contact Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. You may also contact the Social Security Administration toll-free at 1-800-772-1213, at www.ssa.gov, or call your local Social Security Administration office.

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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.

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, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

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 the pursuit of its right of recovery. The plan's 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 recovery rights by providing requested information.

This provision will not apply to benefits payable under the Pennsylvania Motor Vehicle Finance Responsibility Law or under Act III, Health Care Services Malpractice Act of Pennsylvania.

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Payment of Benefits

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, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

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

Even if the payment of healthcare benefits to a Non-Participating Provider has been authorized by you, Cigna may,

at its option, make payment of benefits to you. When benefits are paid to you or your 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 one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

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

Calculation of Covered Expenses

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

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

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Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

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

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

Injury or Sickness

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

Dependents

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

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

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

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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 01-11

Federal Requirements

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

HC-FED1 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.

Notice Regarding Pharmacy Directories and Pharmacy Networks

A list of network pharmacies is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of pharmacies 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 not be considered a Late Entrant for Dependent Insurance.

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

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

HC-FED4 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). 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.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - 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 a current or former Employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the Employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an Employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

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

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

HC-FED96 04-17

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 your Employer agrees, and you meet the criteria shown in the following Sections B through H and enroll for or change coverage within the time period established by your Employer.

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 benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

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

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. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. 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 group 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.

HC-FED95 04-17

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent 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 the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67 09-14

Coverage for Maternity Hospital Stay

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

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

HC-FED11 10-10

Women's Health and Cancer Rights Act (WHCRA)

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

Continuation of Health Insurance During Leave

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

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

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

Reinstatement of Canceled Insurance Following Leave

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

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 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 and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

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

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

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

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

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

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

Reinstatement of Benefits (applicable to all coverages)

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

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

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.

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 Certificate 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 Certificate, 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 Certificate, 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.

HC-FED104 01-19

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

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

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

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

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary 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.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

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

Disability Extension

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

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

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

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

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

Medicare Extension for Your Dependents

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

Termination of COBRA Continuation

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

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;

- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

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

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

Employer's Notification Requirements

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

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

How to Elect COBRA Continuation Coverage

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

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

How Much Does COBRA Continuation Coverage Cost?

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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days

after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within 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 Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

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

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

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

Newly Acquired Dependents

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

COBRA Continuation for Retirees Following Employer's Bankruptcy

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

Conversion Available Following Continuation

If your or your Dependents' COBRA continuation ends due to the expiration of the maximum 18-, 29- or 36-month period, whichever applies, you and/or your Dependents may be entitled to convert to the coverage in accordance with the Medical Conversion benefit then available to Employees and the Dependents. Please refer to the section titled "Conversion Privilege" for more information.

Interaction With Other Continuation Benefits

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

HC-FED66 07-14

ERISA Required Information

The name of the Plan is:

Latitude AI, LLC Health & Welfare Plan

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

Latitude AI, LLC
2545 Railroad Street
Pittsburgh, PA 15222
412-904-1216

Employer Identification Number (EIN):	Plan Number:
921130676	501

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

Employer named above

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

Employer named above

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 Plan's fiscal year ends on 08/31.

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

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

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

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 the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, 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 05-15

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 care 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, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write us at the toll-free number on your 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 your benefit plan will abide by the decision of the IRO.

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

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

Notice of Benefit Determination on Appeal

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

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

Relevant Information

Relevant Information is any document, record or other information 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

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

HC-FED82V1 03-14

Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

HC-SPP4 04-10
V1

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-AAR1 01-17

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

Ambulance

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

HC-DFS1406 01-20

Ancillary Charge

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

is the amount by which the cost of the requested Brand Drug exceeds the cost of the Generic Drug.

HC-DFS1562 01-21

Biologic

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

HC-DFS840 10-16

Biosimilar

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

HC-DFS841 10-16

Brand Drug

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

HC-DFS842 10-16

Business Decision Team

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

HC-DFS1563 10-21

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

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:

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

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

The term child means a child born to you or a child legally adopted by you including that child, from the date of placement in your home, regardless of whether the adoption has become final. It also includes a stepchild or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

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

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

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

HC-DFS1007 10-16

Designated Pharmacy

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

HC-DFS1564 01-21

Domestic Partner

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

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

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

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

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

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

HC-DFS47 04-10
V1

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-DFS1414 01-20

Employee

The term Employee means a full or part-time salaried exempt Employee of the Employer who is currently in Active Service. The term does not include Employees who are temporary or who normally work less than 30 hours a week for the Employer.

HC-DFS1094 M 12-17

Employer

The term Employer means the policyholder and those affiliated Employers whose Employees are covered under this Policy.

HC-DFS1566 01-21

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.

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

HC-DFS1407 01-20

Generic Drug

A Prescription Drug Product that Cigna identifies as a Generic Drug product at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics (including Biosimilars) as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the plan. A Biosimilar may be classified as a Generic Drug for the purposes of benefits under the plan even if it is identified as a "brand name" drug by the manufacturer, Pharmacy or your Physician.

HC-DFS846 10-16

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

HC-DFS1415 01-20
V2

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 Drug Product

A Prescription Drug Product that is prescribed for use over an extended period of time for the treatment of chronic or long-term conditions such as asthma, hypertension, diabetes and heart disease, and is identified principally based on consideration of available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source and clinical factors. For the purposes of benefits, the list of your plan's Maintenance Drug Products does not include compounded medications, Specialty Prescription Drug Products or Prescription Drug Products, such as certain narcotics that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or Refill under applicable federal or state law. You may determine whether a drug is a Maintenance Medication by calling member services at the telephone number on your ID card.

HC-DFS847 10-16

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 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 schedule that 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-DFS1196 01-19

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 Professional 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-DFS1410 01-20

Medically Necessary/Medical Necessity

Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are

all of the following as determined by a Medical Director or Review Organization:

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

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

HC-DFS1411 01-20

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

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

HC-DFS1409 01-20

Network Pharmacy

A retail or home delivery Pharmacy that has:

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

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

HC-DFS1198 01-19

New Prescription Drug Product

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

HC-DFS1568 01-21

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

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.

HC-DFS1412 01-20

Other Health Professional

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-DFS1413 01-20

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

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

HC-DFS851 10-16

Pharmacy & Therapeutics (P&T) Committee

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

HC-DFS1570 01-21

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 Charge

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

HC-DFS1191 01-19

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) into coverage tiers. This list is 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. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.

HC-DFS1571 01-21

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, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips;
- Insulin
- Injection aids
- Pre-filled insulin pens and cartridges
- Pharmacological agents for controlling blood sugar
- 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-DFS1049 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 Care Medications

The Prescription Drug Products or other medications (including over-the-counter medications) designated as payable by the plan at 100% of the cost (without application of any Deductible, Copayment or Coinsurance) as required by applicable law under any of the following:

- 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.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

A written prescription is required to process a claim for a Preventive Care Medication. You may determine whether a drug is a Preventive Care Medication through the internet website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-DFS857 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

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

Room and Board

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

HC-DFS1408 01-20

Sickness – For Medical Insurance

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

HC-DFS279 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 Prescription Drug Product or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Prescription Drug Product or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug Product or Medical Pharmaceutical has a high acquisition cost; and, whether the Prescription Drug Product or Medical Pharmaceutical is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug Product or Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty

Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, or by tier assignment or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

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
V1

Therapeutic Alternative

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

HC-DFS859 10-16

Therapeutic Equivalent

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

HC-DFS860 10-16

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
V1

Usual and Customary (U&C) Charge

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

HC-DFS861 10-16

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $0/individual or $0/family For out-of-network providers: $1,000/individual or $2,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Out-of-network immunizations through age 20, out-of-network prescription drugs, out-of-network emergency room visits, out-of-network urgent care facility visits.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $1,250/individual or $2,500/family For out-of-network providers: $10,000/individual or $20,000/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay/visit	40% coinsurance	None
	Specialist visit	$25 copay/visit	40% coinsurance	None
	Preventive care/ screening/ immunization	No charge/visit No charge/screening No charge/immunizations No charge/immunizations	40% coinsurance/visit 40% coinsurance/ screening 40% coinsurance/ immunizations** 40% coinsurance/ immunizations **Deductible does not apply	None None Coverage birth through age 20 Coverage age 21 and older You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$150 copay per type of scan/day	40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	$10 copay/prescription (retail 30 days), $20 copay/prescription (retail & home delivery 90 days)	40% coinsurance/prescription (retail); Not covered (home delivery) Deductible does not apply	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail) and 90 day supply (home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	$40 copay/prescription (retail 30 days), $80 copay/prescription (retail & home delivery 90 days)	40% coinsurance/prescription (retail); Not covered (home delivery) Deductible does not apply	
	Non-preferred brand drugs (Tier 3)	$75 copay/prescription (retail 30 days), $150 copay/prescription (retail & home delivery 90 days)	40% coinsurance/prescription (retail); Not covered (home delivery) Deductible does not apply	
	Specialty drugs (Tier 4)	$95 copay/self- administered injectable prescription (retail 30 days) $190 copay/self-administered injectable prescription (home delivery and retail 90 days)	40% coinsurance/prescription (retail); Not covered (home delivery) Deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% coinsurance	None
	Physician/surgeon fees	No charge	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$175 copay/visit	$175 copay/visit Deductible does not apply	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share.
	Emergency medical transportation	No charge	No charge Deductible does not apply	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	$25 copay/visit	$25 copay/visit Deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	40% coinsurance	50% penalty for no out-of-network precertification.
	Physician/surgeon fees	No charge	40% coinsurance	50% penalty for no out-of-network precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/office visit No charge/all other services	40% coinsurance/office visit 40% coinsurance/all other services	50% penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.). Includes medical services for MH/SA diagnoses.
	Inpatient services	No charge	40% coinsurance	50% penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	40% coinsurance	
	Childbirth/delivery facility services	No charge	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	40% coinsurance	Coverage is limited to 60 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$10 copay/PCP visit $25 copay/ Specialist visit	40% coinsurance/PCP visit 40% coinsurance/ Specialist visit	Coverage is limited to annual max of: 60 days for Rehabilitation services; 36 days for Cardiac rehab services; 60 days for Chiropractic care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$10 copay/PCP visit $25 copay/ Specialist visit	40% coinsurance/PCP visit 40% coinsurance/ Specialist visit	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	No charge	40% coinsurance	50% penalty for no out-of-network precertification. Coverage is limited to 100 days annual max.
	Durable medical equipment	No charge	40% coinsurance	None
	Hospice services	No charge/inpatient services No charge/outpatient services	40% coinsurance/inpatient services 40% coinsurance/outpatient services	50% penalty for failure to precertify out-of-network inpatient hospice services.
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 days)
- Chiropractic care (60 days)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Pennsylvania Insurance Department at 1-877-881-6388 and Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or Pennsylvania Insurance Department at 1-877-881-6388. Additionally, a consumer assistance program can help you file your appeal. Contact: Pennsylvania Consumer Assistance Program at (877) 881-6388.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$40

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$640

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$300

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: OAP **Ben Ver:** 28 **Plan ID:** 17394990

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DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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 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
PO 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, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

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

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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 711 را شماره‌گیری کنید).

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BENEFIT SUMMARY

Cigna Health and Life Insurance Co.
For - Latitude AI LLC
Open Access Plus Plan
OAP
Effective - 01/01/2024

Selection of a Primary Care Provider - your plan may require or allow 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. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. 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.

Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care 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.

A notice for Missouri residents required by RSMo 376.1199.6: This plan has purchased an optional rider to cover elective abortions. The enrollee has the right to exclude, and not pay for, coverage for elective abortions if such coverage is contrary to the enrollee's moral, ethical or religious beliefs.

A notice for Texas residents per Tex. Ins. Code §1218.001 et.al.: This plan has purchased an optional rider to cover elective abortions. The enrollee has the right to exclude from their plan, and not pay for, coverage for elective abortions.

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.	
Plan Coinsurance	Plan pays 100%	Plan pays 60%
Maximum Reimbursable Charge	Not Applicable	110%
Plan Deductible	Individual: None Family: None	Individual: $1,000 Family: $2,000

- The amount you pay for out-of-network covered expenses counts towards your out-of-network deductibles.
- Benefit copays/deductibles always apply before plan deductible and coinsurance.
- Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.

Note: Services where plan deductible applies are noted with a caret (^).

Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual: $1,250 Family: $2,500	Individual: $10,000 Family: $20,000

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.
- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	$10 copay, and plan pays 100%	Plan pays 60% ^
Specialty Care Physician Services/Office Visit	$25 copay, and plan pays 100%	Plan pays 60% ^
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit	Plan pays 60% ^
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office **Note:** Office copay does not apply if only the allergy serum is provided.	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Virtual Care		
Dedicated Virtual Providers - MDLIVE		
MDLIVE Urgent Virtual Care Services	$10 copay, and plan pays 100%	Not Covered
MDLIVE Primary Care Services	$10 copay, and plan pays 100%	Not Covered
MDLIVE Specialty Care Services	$25 copay, and plan pays 100%	Not Covered

- Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care.
- Lab services supporting a virtual visit must be obtained through dedicated labs.
- Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Virtual Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	$10 copay, and plan pays 100%	Plan pays 60% ^
Specialty Care Physician Services/Office Visit	$25 copay, and plan pays 100%	Plan pays 60% ^
• Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services). • Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting. **NOTE:** Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
Convenience Care Clinic		
Convenience Care Clinic	$10 copay, and plan pays 100%	Plan pays 60% ^
Preventive Care		
Preventive Care	Plan pays 100%	PCP: Plan pays 60% ^ Specialist: Plan pays 60% ^
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit. • Annual Limit: Unlimited		
Immunizations Birth through age 20 Ages 21 and older	Plan pays 100% Plan pays 100%	PCP: Plan pays 60% Specialist: Plan pays 60% PCP: Plan pays 60% ^ Specialist: Plan pays 60% ^
Mammogram, PAP, and PSA Tests	Plan pays 100%	Covered same as other x-ray and lab services, based on Place of Service
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service.		
Inpatient		
Inpatient Hospital Facility Services	Plan pays 100%	Plan pays 60% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs		
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100%	Plan pays 60% ^
Inpatient Professional Services	Plan pays 100%	Plan pays 60% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Outpatient		
Outpatient Facility Services	Plan pays 100%	Plan pays 60% ^
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 100%	Plan pays 60% ^
Emergency Services		
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. • Per visit copay is waived if admitted.	$175 copay, and plan pays 100%	$175 copay, and plan pays 100%
Urgent Care Facility • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	$25 copay, and plan pays 100%	$25 copay, and plan pays 100%
Ambulance	Plan pays 100%	Plan pays 100%
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 100 days	Plan pays 100%	Plan pays 60% ^
Laboratory Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 100%	Plan pays 60% ^
Outpatient Facility	Plan pays 100%	Plan pays 60% ^
Radiology Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 100%	Plan pays 60% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	$150 copay per type of scan per day, and plan pays 100%	Plan pays 60% ^
Physician's Services/Office Visit	$150 copay per type of scan per day, then covered same as Physician Services – Office Visit coinsurance	Covered same as Physician Services - Office Visit

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Outpatient Therapy Services		
Outpatient Therapy Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limits: • All Therapies Combined - Includes Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 60 days • Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.		
Chiropractic Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limit: • Chiropractic Care - 60 days		
Cardiac Rehabilitation Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limit: • Cardiac Rehabilitation - 36 days		
Hospice		
Inpatient Facilities	Plan pays 100%	Plan pays 60% ^
Outpatient Services	Plan pays 100%	Plan pays 60% ^
Note: Includes Bereavement counseling provided as part of a hospice program.		
Bereavement Counseling (for services not provided as part of a hospice program)		
Services Provided by a Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Medical Pharmaceutical Drugs		
Cigna Pathwell Specialty℠ Medical Pharmaceuticals	**Cigna Pathwell Specialty℠ Network:** Plan pays 100% **All other medical network providers:** Not Covered	Not Covered
Other Medical Pharmaceuticals	Plan pays 100%	Not Covered
Note: This benefit only applies to the cost of Medical Pharmaceutical drugs administered. Related Facility, Office Visit or Professional charges are covered according to the plan design.		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Maternity		
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 100%	Plan pays 60% ^
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Delivery - Facility (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Abortion		
Abortion Services Rider	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Note: Elective and non-elective procedures		
Family Planning		
Women's Services	Plan pays 100%	Coverage varies based on Place of Service
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)		
Men's Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
Infertility		
Infertility Treatment	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. • Lifetime Maximum: Unlimited		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Other Health Care Facilities/Services		
Home Health Care • Annual Limit: 60 days (The limit is not applicable to mental health and substance use disorder conditions.) • 16 hour maximum per day **Note:** Includes outpatient private duty nursing when approved as medically necessary	Plan pays 100%	Plan pays 60% ^
Organ Transplants		
Inpatient Hospital Facility Services		
LifeSOURCE Facility	Plan pays 100%	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Inpatient Professional Services		
LifeSOURCE Facility	Plan pays 100%	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Professional benefit	Covered same as plan's Inpatient Professional benefit
• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: Unlimited maximum per Transplant per Lifetime		
Durable Medical Equipment • Annual Limit: Unlimited	Plan pays 100%	Plan pays 60% ^
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan pays 100%	Plan pays 60% ^
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	Plan pays 100%	Plan pays 60% ^
Temporomandibular Joint Disorder (TMJ) • Unlimited Non-Surgical lifetime maximum **Note:** Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Routine Foot Care **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	Not Covered	Not Covered
Routine Eye Care	Plan pays 100%	Plan pays 60% ^
Acupuncture • Annual Limit: 12 days	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Mental Health and Substance Use Disorder		
Inpatient Mental Health	Plan pays 100%	Plan pays 60% ^
Outpatient Mental Health – Physician's Office	$10 copay, and plan pays 100%	Plan pays 60% ^
Outpatient Mental Health – All Other Services	Plan pays 100%	Plan pays 60% ^
Inpatient Substance Use Disorder	Plan pays 100%	Plan pays 60% ^
Outpatient Substance Use Disorder – Physician's Office	$10 copay, and plan pays 100%	Plan pays 60% ^
Outpatient Substance Use Disorder – All Other Services	Plan pays 100%	Plan pays 60% ^

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.
- Services are paid at 100% after you reach your out-of-pocket maximum.

Important Note on Mental Health and Substance Use Disorder Coverage: Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled "Mental Health and Substance Use Disorder."

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Cigna Total Behavioral Health - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- inMynd℠ program - a comprehensive, holistic solution to help recognize and find resources to treat behavioral health conditions.

Pharmacy	In-Network	Out-of-Network
Cost Share and Supply		
Cigna Pharmacy Plus Cost Share • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply (except Specialty up to 90-day supply) • Oral specialty medications are covered at Non-Specialty cost share	**Retail (per 30-day supply):** Generic: You pay $10 Preferred Brand: You pay $40 Non-Preferred Brand: You pay $75 **Retail (per 30-day supply):** Injectables Specialty: You pay $95 **Retail and Home Delivery (per 90-day supply):** Injectables Specialty: You pay $190 **Retail and Home Delivery (per 90-day supply):** Generic: You pay $20 Preferred Brand: You pay $80 Non-Preferred Brand: You pay $150	**Retail:** You pay 40% Your plan pays 60% **Home Delivery:** Not Covered

- Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies.
- Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or network home delivery pharmacy. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or network home delivery pharmacy to be covered by the plan.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When patient requests brand drug, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW).
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.

Drugs Covered

Prescription Drug List:
Your Cigna Value Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. Some of the more expensive drugs are excluded when there are less expensive alternatives. To check which drugs are included in your plan, please log on to myCigna.com.
Some highlights:

- Coverage includes Self Administered injectables and optional injectable drugs – but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Oral Fertility drugs are covered.

Pharmacy Program Information

Pharmacy Clinical Management: Essential

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

Patient Assurance Program

Your plan includes the Patient Assurance Program, which waives the deductible and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally:

- Any amount you pay for these medications only count toward meeting your out-of-pocket maximum.
- Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum.

Additional Information

Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Comprehensive Oncology Program • Care Management outreach • Case Management	Included
Health Advisor - A Support for healthy and at-risk individuals to help them stay healthy • Health Assessments • Health and Wellness Coaching • Gaps in Care Coaching • Treatment Decision Support • Educate and Refer	Included

Additional Information

Healthy Pregnancies/Healthy Babies • Care Management outreach • Maternity Case Management • Neo-natal Case Management	$150 (1st trimester) / $75 (2nd trimester) - Option 3

Maximum Reimbursable Charge
The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (110%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. 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. Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level as required by applicable state or federal law if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or federal law.

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

Medicare Coordination
In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

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.

One Guide
Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

Additional Information

Pre-Certification - Continued Stay Review – Basic Care Standard Management Inpatient - required for all inpatient admissions
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 50% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

Pre-Certification - Basic Care Standard Management Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 50% penalty applied to outpatient procedures charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures reviewed by Cigna Healthcare and not certified.

Pre-Existing Condition Limitation (PCL) does not apply.

Your Health First - 200
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Definitions

Coinsurance - After you've reached your out-of-network deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Place of service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- 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 your 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 Cigna. 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;

Exclusions

- 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 plan; or
- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to 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: macromastia or gynecomastia surgeries; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- 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 six months of an accident.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long-term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Care Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Care Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.

Exclusions

- 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 corrective lenses, or the first set of eyeglass lenses and frames and associated services for treatment of keratoconus or following cataract surgery).
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.
- Membership costs 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.
- Enteral feedings, supplies and specialty formulated medical foods that are prescribed and non-prescribed, except for infant formula needed for the treatment of inborn errors of metabolism.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit
- Massage therapy.

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate, service agreement or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Care Solutions, Inc., Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation.

EHB State: PA

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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 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
PO 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, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

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

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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 711 را شماره‌گیری کنید).

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Latitude AI, LLC

OPEN ACCESS PLUS MEDICAL BENEFITS

Health Savings Account

EFFECTIVE DATE: March 1, 2023

CN003

3344486

This document printed in April, 2023 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Latitude AI, LLC

GROUP POLICY(S) — COVERAGE
3344486 – HSAF/HSAI OPEN ACCESS PLUS MEDICAL BENEFITS

EFFECTIVE DATE: March 1, 2023

THIS CERTIFICATE CONTAINS A PREFERRED PROVIDER ARRANGEMENT FOR MEDICAL BENEFITS.

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

Geneva Cambell Brown, Corporate Secretary

Julia M. Huggins, President

Explanation of Terms

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

The Schedule

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

Special Plan Provisions

When you select a Participating Provider, 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-SPP1 04-10
V1

When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Professionals and Other Health Care Facilities. 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-SPP63 01-20

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 insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the

treatment program remains appropriate to the patient's needs.

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

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V1

Additional Programs

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

HC-SPP3 04-10
V1

Care Management and Care Coordination Services

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

HC-SPP27 06-15
V1

Important Notices

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care 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 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 your plan and Prescription Drug Products included on the Prescription Drug List. 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 may also, conduct business with various pharmaceutical manufacturers separate and apart from this plan's Medical Pharmaceutical and Prescription Drug Product 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 and Prescription Drug Products. 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 and Prescription Drug Product 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.

If Cigna determines that a Pharmacy, pharmaceutical manufacturer or other third party is or has waived, reduced, or forgiven any portion of the charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Prescription Drug Product without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of plan benefits in connection with the Prescription Drug Product, 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 Pharmacy, pharmaceutical manufacturer or other third party represents that you remain responsible for any amounts that your 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.

For example, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a Prescription Drug Product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.

HC-IMP260 08-19
V7

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, including sex stereotypes and gender identity. Coverage for medically necessary health services is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. Cigna will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. Cigna will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

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 01-20
V4

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

Important Notices

PLEASE READ THIS NOTICE CAREFULLY; IT CONTAINS IMPORTANT INFORMATION YOU SHOULD KNOW BEFORE YOU ELECT COVERAGE.

THIS MATERIAL IS NOT INTENDED TO SUPPLEMENT OR REPLACE ANY PLAN DOCUMENTS APPLICABLE ONCE YOU DO ELECT COVERAGE. IF COVERAGE IS ELECTED, ALL OF YOUR RIGHTS AND OBLIGATIONS UNDER YOUR PLAN SHALL BE GOVERNED BY THE APPLICABLE PLAN DOCUMENTS.

Listing of Information Available Upon Request

The following information may be available to you upon request to Customer Service:

- A list of the Provider Organization's officers and directors including their business addresses and official positions.
- A copy of the Provider Organization's confidentiality procedures.

- A description of the credentialing process for providers.
- A list of the participating providers affiliated with participating Hospitals.
- Whether a specifically identified drug is included or excluded from coverage.
- A description of the process by which a health care provider can prescribe specific drugs used for an off-label purpose, biologicals and medications not included in the Prescription Drug List for the prescription drugs or biologicals, when the Prescription Drug List's equivalent has been ineffective in the treatment of the enrollee's disease, or if the drug causes or is reasonably expected to cause adverse or harmful reactions to the enrollee.
- A description of the procedures followed by Cigna Health and Life Insurance Company (Cigna) to make decisions about the experimental nature of individual drugs, medical devices or treatments.
- A summary of the methodologies used by Cigna to reimburse for health care services.
- A description of procedures used in the Provider organization's quality assurance program.

HC-IMP62 04-11
V1

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

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

WARNING: Any person who knowingly and with intent to defraud any insurance company or another 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 fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

HC-CLM25 01-20
V22

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 30 hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within 3 months after your insurance ceased.

Eligibility for Dependent Insurance

You will become eligible for Dependent Insurance on the later of:

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

Waiting Period

None.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

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

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

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

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

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns

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

HC-ELG224 M 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 medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

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, if you choose.

Continuity Of Care

A new enrollee may continue an ongoing course of treatment with a nonparticipating health care provider, or a covered person with a participating provider when the plan initiates termination of the provider's contract, except for cause including fraud, breach of contract, criminal activity or posing a danger to health or safety. Treatment may continue, at the covered person's option, for a transitional period of up to 60 days from enrollment from the date the covered person was notified by the plan of the termination, under the same terms and conditions as those applicable for participating providers. If considered clinically appropriate by the plan, the transitional period may be extended. When the covered person is in the second or third trimester of pregnancy, the transitional period shall extend through postpartum care related to the delivery.

HC-IMP1 04-10

V3

Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

If 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 Covered Expenses that an insured person is required to pay under the plan in addition to the Deductible, if any.

Copayments/Deductibles

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

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

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

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

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

- Coinsurance.
- Plan Deductible.

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

- Non-compliance penalties.
- Any copayments and/or benefit deductibles.
- Provider charges in excess of the Maximum Reimbursable Charge.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

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

Open Access Plus Medical Benefits

The Schedule

Note:
For information about your health fund benefit 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".

Multiple Surgical Reduction

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

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

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

Co-Surgeon

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

Out-of-Network 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 other facility as required by Pennsylvania law, 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). 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	100%	80% 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.	Not Applicable	110%
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.		
Calendar Year Deductible Individual Family Maximum Family Maximum Calculation **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.	 $2,000 per person $4,000 per family	 $2,000 per person $4,000 per family

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Combined Medical/Pharmacy Calendar Year Deductible		
Combined Medical/Pharmacy Deductible: includes retail and home delivery drugs	Yes	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Deductible	Yes	In-Network coverage only
Out-of-Pocket Maximum		
Individual – Employee Only	$4,000 per person	$4,000 per person
Individual – within a Family	$4,000 per person	$4,000 per person
Family Maximum	$6,000 per family	$6,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		
Combined Medical/Pharmacy Out-of-Pocket Maximum		
Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery drugs	Yes	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	Yes	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
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 100%	Plan deductible, then 80%
Specialty Care Physician	Plan deductible, then 100%	Plan deductible, then 80%
Second Opinion Consultations (provided on a voluntary basis)		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Allergy Treatment/Injections		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Allergy Serum (dispensed by the Physician in the office)		
Primary Care Physician	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician	Plan deductible, then 100%	Plan deductible, then 80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Virtual Care **Dedicated Virtual Providers** Services available through contracted virtual providers as medically appropriate.		
Urgent Virtual Care Services	Plan deductible, then 100%	In-Network coverage only
Dedicated Virtual Primary Care Physician	Plan deductible, then 100%	In-Network coverage only
Dedicated Virtual Specialty Care Physician	Plan deductible, then 100%	In-Network coverage only
Note: Dedicated Virtual Providers may deliver services that are payable under other benefits (e.g., Preventive Care, Primary Care Physician, Behavioral; Dermatology/Specialty Care Physician). Lab services supporting a virtual visit must be obtained through dedicated labs.		
Virtual Physician Services Services available through Physicians as medically appropriate. **Note:** Preventive services covered at the preventive level.		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Preventive Care		
Routine Preventive Care - all ages		
Primary Care Physician's Office Visit	100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	100%	Plan deductible, then 80%
Immunizations (for children through age 20)		
Primary Care Physician's Office Visit	100%	80%
Specialty Care Physician's Office Visit	100%	80%
Immunizations (for ages 21 and over)		
Primary Care Physician's Office Visit	100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	100%	Plan deductible, then 80%
Mammograms, PSA, PAP Smear		
Preventive Care Related Services (i.e. "routine" services)	100%	Subject to the plan's x-ray benefit & lab benefit; based on place of service. Plan deductible does not apply to PAP Smear.
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
Inpatient Hospital - Facility Services	Plan deductible, then 100%	Plan deductible, then 80%
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 100%	Plan deductible, then 80%
Inpatient Hospital Physician's Visits/Consultations	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 80%
Surgeon		
Radiologist, Pathologist, Anesthesiologist		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Professional Services Surgeon Radiologist, Pathologist, Anesthesiologist	Plan deductible, then 100%	Plan deductible, then 80%
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 100%	Plan deductible, then 100%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the 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 $150 per visit copay (waived if admitted), then 100%	Plan deductible, then $150 per visit copay (waived if admitted), then 100%
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 $150 per visit copay (waived if admitted), then 100%	Plan deductible, then $150 per visit copay (waived if admitted), then 100%
Ambulance	Plan deductible, then 100%	Plan deductible, then 100%
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 100 days combined	Plan deductible, then 100%	Plan deductible, then 80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Laboratory Services		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Hospital Facility	Plan deductible, then 100%	Plan deductible, then 80%
Independent Lab Facility	Plan deductible, then 100%	Plan deductible, then 80%
Radiology Services		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Hospital Facility	Plan deductible, then 100%	Plan deductible, then 80%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Therapy Services Calendar Year Maximum: 60 days for all therapies combined (The limit is not applicable to mental health conditions.) **Note:** The Outpatient Therapy Services maximum does not apply to the treatment of autism. Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Cardiac Rehabilitation Calendar Year Maximum: 36 days		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Chiropractic Care Calendar Year Maximum: 60 days		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Acupuncture Self-referred, Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis, limited to a 12 day maximum per person per Contract Year		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Home Health Care Services Calendar Year Maximum: 60 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 100%	Plan deductible, then 80%
Hospice		
Inpatient Services	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Services (same coinsurance level as Home Health Care Services)	Plan deductible, then 100%	Plan deductible, then 80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Bereavement Counseling		
Services provided as part of Hospice Care		
Inpatient	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient	Plan deductible, then 100%	Plan deductible, then 80%
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 80%
Home Care	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
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 100%	In-Network coverage only
Outpatient Facility	Plan deductible, then 100%	In-Network coverage only
Inpatient Professional Services	Plan deductible, then 100%	In-Network coverage only
Outpatient Professional Services	Plan deductible, then 100%	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 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Plan deductible, then 100%	Plan deductible, then 80%
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 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Delivery - Facility (Inpatient Hospital, Birthing Center)	Plan deductible, then 100%	Plan deductible, then 80%
Abortion		
Includes elective and non-elective procedures		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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 80%
Specialty Care Physician	100%	Plan deductible, then 80%
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)		
Primary Care Physician's Office Visit	100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	100%	Plan deductible, then 80%
Inpatient Facility	100%	Plan deductible, then 80%
Outpatient Facility	100%	Plan deductible, then 80%
Inpatient Professional Services	100%	Plan deductible, then 80%
Outpatient Professional Services	100%	Plan deductible, then 80%
Men's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling		
Primary Care Physician	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician	Plan deductible, then 100%	Plan deductible, then 80%
Surgical Sterilization Procedures for Vasectomy (excludes reversals)		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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). • Artificial Insemination, In-vitro, GIFT, ZIFT, etc.		
Physician's Office Visit (Lab and Radiology Tests, Counseling)		
Primary Care Physician	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 80%
Lifetime Maximum: Unlimited Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).		
Transplant Services and Related Specialty Care Includes all medically appropriate, non-experimental transplants		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Facility	Plan deductible, then 100% at LifeSOURCE center, otherwise plan deductible, then 100%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 100% at LifeSOURCE center, otherwise plan deductible, then 100%	Plan deductible, then 80%
Lifetime Travel Maximum: Unlimited	Plan deductible, then 100% (only available when using LifeSOURCE facility)	In-Network coverage only
Durable Medical Equipment Calendar Year Maximum: Unlimited	Plan deductible, then 100%	Plan deductible, then 80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
External Prosthetic Appliances Calendar Year Maximum: Unlimited	Plan deductible, then 100%	Plan deductible, then 80%
Diabetic Equipment Calendar Year Maximum: Unlimited	Plan deductible, then 100%	Plan deductible, then 80%
Nutritional Counseling Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of diabetes and/or to mental health and substance use disorder conditions.		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 80%
Enteral Nutrition (Nutritional Formulas)	Plan deductible, then 100%	Plan deductible, then 80%
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 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 80%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to teeth.		
Primary Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Specialty Care Physician's Office Visit	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Facility	Plan deductible, then 100%	Plan deductible, then 80%
Inpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient Professional Services	Plan deductible, then 100%	Plan deductible, then 80%
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.
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 100%	Plan deductible, then 80%
Outpatient		
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 100%	Plan deductible, then 80%

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 100%	Plan deductible, then 80%
Outpatient		
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 100%	Plan deductible, then 80%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 100%	Plan deductible, then 80%

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, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will be reduced by 50% for Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission.

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

- Hospital charges for Room and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

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

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

Outpatient Certification Requirements – Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient 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 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 be reduced by 50% for charges made for any outpatient procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

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

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

Outpatient Procedures

Including, but not limited to:

- 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 policy.

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

- inpatient Hospital services, except for 48/96 hour maternity stays.
- inpatient services at any participating Other Health Care Facility.
- residential treatment.

- non-emergency Ambulance.
- certain Medical Pharmaceuticals.
- radiation therapy.
- transplant services.

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 for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital, subject to the limits as shown in The Schedule.
- charges for inpatient Room and Board and other Necessary Services and Supplies made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility as shown in The Schedule.
- charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
- charges for outpatient medical care and treatment received at a Hospital.
- charges for outpatient medical care and treatment received at a Free-Standing Surgical Facility.
- charges for Emergency Services.
- charges for Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse for professional nursing service.
- charges made for anesthetics, including, but not limited to supplies and their administration.
- charges for diagnostic x-ray.
- charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.
- charges for chemotherapy.
- charges for blood transfusions.
- charges for oxygen and other gases and their administration.
- charges made for Medically Necessary foot care for diabetes, peripheral neuropathies and peripheral vascular disease.
- charges made for or in connection with mammograms, including digital breast tomosynthesis, for breast cancer screening and diagnosis, not to exceed: a baseline mammogram annually for women age 40 and over; and a mammogram upon a Physician's recommendation for women under age 40.
- charges for an annual gynecological exam, including a pelvic exam and a routine pap smear. No dollar limit or Deductible may be applied to routine pap smears.
- charges for colorectal cancer screening for non-symptomatic persons who are 50 years of age or older shall include, but not be limited to: an annual fecal occult blood test; a sigmoidoscopy, a screening barium enema or a test consistent with approved medical standards and practices to detect colon cancer, at least once every 5 years; and a colonoscopy at least once every 10 years.

  Coverage for symptomatic persons shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating Physician. "Symptomatic person" means an individual who experiences a change in bowel habits, rectal bleeding or persistent stomach cramps, weight loss or abdominal pain.

  Coverage for a non-symptomatic person at high or increased risk for colorectal cancer who is under 50 years of age shall include a colonoscopy or any combination of colorectal cancer screening tests in accordance with the American Cancer Society guidelines on screening for colorectal cancer published as of January 1, 2008. "Non-symptomatic person at high or increased risk" means an individual who poses a higher than average risk for colorectal cancer.
- charges made for screening prostate-specific antigen (PSA) testing.
- 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 and vasectomies.
- charges for the following preventive care services as defined by recommendations from the following:
  - the U.S. Preventive Services Task Force (A and B recommendations);
  - the Advisory Committee on Immunization Practices (ACIP) for immunizations;
  - the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;
  - the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
  - with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.

  Detailed information is available at www.healthcare.gov. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.
- charges for childhood immunizations, including the immunizing agents and Medically Necessary booster doses. Immunizations provided in accordance with Advisory Committee on Immunization Practices (ACIP) standards are covered for any insured person under age 21 and are exempt from Deductibles or dollar limits.
- charges made for surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.
- charges made for acupuncture services involving the stimulation of specific anatomical locations on the skin through the penetration of fine needles, for the purpose of relieving pain or treating disease as medically necessary.

Virtual Care

Dedicated Virtual Providers

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

Virtual Physician Services

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

Behavioral consultations and services via secure telecommunications technologies that shall include video capability, including telephones and internet, when delivered through a behavioral provider.

- charges made for treatment of Serious Mental Illness. Such Covered Expenses will be payable the same as for other illness.
- charges for at least 48 hours of inpatient care following a mastectomy. A longer period of time will be covered if the treating Physician determines it is Medically Necessary. Home health care services will also be provided if the treating Physician deems these services Medically Necessary.
- charges made for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders for covered persons under age 21.

  "Autism spectrum disorders" means any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.
- charges for Hospital Confinement of a mother and her newborn child for 48 hours following a vaginal delivery, or for 96 hours following a cesarean section. The mother may request an earlier discharge, if after consulting with her Physician, it is determined that less time is needed for recovery.
- charges for services provided to the newborn will be absorbed within the mother's cost-sharing limitation. A separate deductible does not apply to the child until the child is separately enrolled as a dependent after the first 31 days of the child's life.
- charges made for one postpartum home health care visit, within 48 hours following discharge from the Hospital of the mother and newborn, provided that discharge occurs prior to:
  - 48 hours for normal vaginal delivery; or
  - 96 hours for a cesarean section.

  Postpartum home health care visits will be covered for women if determined to be Medically Necessary. No Copayment, Coinsurance or Deductible will apply to postpartum home health care services.
- the following benefits will apply to insulin-dependent, and non-insulin-dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:
  - charges for Durable Medical Equipment, including glucometers; blood glucose monitors; insulin pumps; infusion devices and related accessories, including those adaptable for the legally blind; podiatric appliances; and

glucagon emergency kits. A special maximum will not apply.

- charges for training by a Physician with expertise in diabetes management, but limited to the following:
  - Medically Necessary visits when diabetes is diagnosed;
  - Medically Necessary visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
  - visits when reeducation or refresher training is prescribed by the Physician; and
  - medical nutrition therapy related to diabetes management.
  - charges for acupuncture

Nutritional Counseling

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

Enteral Nutrition

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

Coverage includes Medically Necessary nutritional supplements for the treatment of inborn errors of metabolism (e.g. disorders of amino acid or organic acid metabolism).

Benefits for nutritional support (formulas) as Medically Necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a Physician.

Internal Prosthetic/Medical Appliances

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

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Home Health Care Services

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

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

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

Covered services include:

- skilled nursing services provided by a Registered Nurse (RN); Licensed Practical Nurse (LPN); Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse (APRN).
- services provided by health care providers such as a physical therapist; occupational therapist or speech therapist.
- services of a home health aide when provided in direct support of those Nurses and health care providers.
- necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.

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

The following are excluded from coverage:

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

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

HC-COV1007 01-21

Hospice Care Services

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

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

HC-COV882 01-20

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.

Inpatient Detoxification Services

Inpatient detoxification for the diagnosis and treatment of abuse of or addiction to alcohol and/or drugs, or alcohol in combination with drugs shall be provided either in a Hospital or in an inpatient non-Hospital facility which is licensed as an alcoholism and/or drug addiction treatment program and meets the requirements of Pennsylvania law. Before an insured may qualify to receive benefits under this section, a Physician or Psychologist must certify the insured as a person suffering from alcohol or drug abuse or dependency and must refer the insured for the appropriate treatment. The following services are covered under inpatient detoxification:

- lodging and dietary services;
- Physician, Psychologist, Nurse, certified addictions counselor and trained staff services;
- diagnostic x-ray;
- psychiatric, psychological and medical laboratory testing; and
- drugs, medicines, equipment use and supplies.

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.

HC-COV137 04-10
V3

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.

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

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

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

HC-COV1008 01-21

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription 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;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- non-foot orthoses primarily used for cosmetic rather than functional reasons; and

- non-foot orthoses primarily for improved athletic performance or sports participation.

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

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

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

Coverage for replacement is limited as follows:

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

The following are specifically excluded external prosthetic appliances and devices:

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

HC-COV1009 01-21

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

  Infertility is defined as:

  - the inability of opposite-sex partners to achieve conception after at least 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:

  - 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-COV824 03-19

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

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

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

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

Therapy services that are not covered include:

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

Coverage is administered according to the following:

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

HC-COV1012 01-21

Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement 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.

Cigna does not deny eligibility or continued eligibility for enrollment or to renew coverage under this plan for these services.

HC-COV1080 01-21

Transplant Services and Related Specialty Care

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. Implantation procedures for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO), ventricular assist device (VAD), and intra-aortic balloon pump (IABP) are also covered.

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

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

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

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

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

Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is the

donor for an organ/tissue transplant; the transplant recipient's plan would cover all donor costs.

HC-COV1013 01-21

Medical Pharmaceuticals

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

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. 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.

The following diabetic supplies are also covered under the plan's medical benefit: alcohol pads, swabs, wipes, Glucagon/Glucagen, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips, insulin, injection aids, pre-filled insulin pens and cartridges, pharmacological agents for controlling blood sugar.

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

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

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

HC-COV1039 01-21

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-COV886 01-20

Clinical Trials

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. Cigna does not deny eligibility for enrollment in its plans for any member who participates in a Clinical Trial. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

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

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

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

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

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

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

Examples of routine patient care costs and services include:

- radiological services;

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

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

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

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Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, for a reason other than failure of the person to pay premium or if the policy is replaced by similar group insurance within 31 days, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by Cigna only to a person who:

- resides in a state that requires offering a conversion policy,
- is Entitled to Convert, and
- applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled to Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased but only if:

- you are not eligible for other individual insurance coverage on a guaranteed issue basis.
- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

If you retire, you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for other individual insurance coverage on a guaranteed issue basis, is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other

plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy

If you reside in a state that requires the offering of a conversion policy, the Converted Policy will be one of Cigna's current conversion policy offerings available in the state where you reside, as determined based upon Cigna's rules.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are Entitled to Convert it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

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Prescription Drug Benefits
The Schedule

For You and Your Dependents

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

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

Coinsurance

The term Coinsurance means the percentage of charges for covered Prescription Drug Products that you or your Dependent are required to pay under this plan.

Copayments (Copay)

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

Oral Chemotherapy Medication

Prescription self-injectable and oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered at Network Pharmacies at 100% after deductible and if applicable at non-Nework Pharmacies, on a basis no less favorable than the out of network medical cost share for injectable/IV chemotherapy.

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Calendar Year Deductible		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Patient Assurance Program Your plan offers additional discounts for certain covered Prescription Drug Products that are dispensed by a retail or home delivery Network Pharmacy included in what is known as the "Patient Assurance Program". As may be described elsewhere in this plan, from time to time Cigna may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your Out-of-Pocket Expenses for certain covered Prescription Drug Products for which Cigna directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna for certain covered Prescription Drug Products included in the Patient Assurance Program is applied or credited to a portion of your Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drug Products as set forth in The Schedule may be reduced in order for Patient Assurance Program discounts earned by Cigna to be applied or credited to the Copayment or Coinsurance, if any, as described above. For example, certain insulin product(s) covered under the Prescription Drug Benefit for which Cigna directly or indirectly earns a discount in connection with the Patient Assurance Program shall result in a credit toward some or all of your Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in The Schedule, for the insulin product. In addition, the covered insulin products eligible for Patient Assurance Program discounts shall not be subject to the Deductible, if any. Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum. Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum. Please note that the Patient Assurance Program discounts that Cigna may earn for Prescription Drug Products, and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any rebates or other payments that Cigna may earn from a pharmaceutical manufacturer for the same or other Prescription Drug Products. Except as may be noted elsewhere in this plan, you are not entitled to the benefit of those rebates or other payments earned by Cigna because they are unrelated to the Patient Assurance Program. Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drug Products included in the Patient Assurance Program and/or your Copayment or Coinsurance, if any for those eligible Prescription Drug Products, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to Cigna in connection with the Patient Assurance Program. More information about the Patient Assurance Program including the Prescription Drug Products included in the program, is available at the website shown on your ID card or by calling member services at the telephone number on your ID card.		
Out-of-Pocket Maximum		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Maintenance Drug Products Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Pharmacy or home delivery Pharmacy.		

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Certain Preventive Care Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required.		
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy**
Certain Specialty Prescription Drug Products are only covered when dispensed by a home delivery Pharmacy.		
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $10 Copay after plan Deductible	40% after plan Deductible
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $40 Copay after plan Deductible	40% after plan Deductible
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $75 Copay after plan Deductible	40% after plan Deductible
Prescription Drug Products at Retail Designated Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Designated Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Designated Pharmacy**
Certain Specialty Prescription Drug Products are only covered when dispensed by a home delivery Pharmacy.		
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill.		
Note: In this context, a retail Designated Pharmacy is a retail Network Pharmacy that has contracted with Cigna for dispensing of covered Prescription Drug Products, including Maintenance Drug Products, in 90-day supplies per Prescription Order or Refill.		
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $20 Copay after plan Deductible	40% after plan Deductible
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $80 Copay after plan Deductible	40% after plan Deductible

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $150 Copay after plan Deductible	40% after plan Deductible
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy**
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $20 Copay after plan Deductible	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $80 Copay after plan Deductible	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $150 Copay after plan Deductible	In-network coverage only

Prescription Drug Benefits

Covered Expenses

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

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

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

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

Prescription Drug List Management

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

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

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Limitations

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

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

for payment of only a Generic Drug Copayment and/or Coinsurance, after satisfying your Deductible, if any.

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

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

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

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

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the diagnosis and the Prescription Drug Product. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

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

Step Therapy

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

Supply Limits

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

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

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

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products.

Designated Pharmacies

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

Synchronization of Prescription Drug Refills

Prescription drug coverage shall provide for the synchronization of prescription drug refills no more than 3 times per year with the exception of unit-of-use packaging that

indicates medication synchronization is not possible or controlled substances classified in Schedule II of The Controlled Substance, Drug, Device and Cosmetic Act.

Prorated daily cost-sharing rate shall apply for the synchronized medication but not apply to dispensing fees. All dispensing fees shall be based on the number of prescriptions filled or refilled.

Synchronization means the coordination of medication refills for a patient taking two or more medications for one or more chronic conditions such that the patient's medications are refilled on the same schedule for a given time period.

New Prescription Drug Products

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

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Your Payments

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

Deductible

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

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

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

Copayment

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

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

Payments at Non-Network Pharmacies

Any reimbursement due to you under this plan for a covered Prescription Drug Product dispensed by a non-Network Pharmacy may be determined by applying the Deductible, if any, and/or non-Network Pharmacy Coinsurance amount set forth in The Schedule to the average wholesale price (or "AWP"), or other benchmark price Cigna applies, for a Prescription Drug Product dispensed by a non-Network Pharmacy. Your reimbursement, if any, for a covered Prescription Drug Product dispensed by a non-Network Pharmacy will never exceed the average wholesale price (or other benchmark price applied by Cigna) for the Prescription Drug Product.

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

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

The amount you or your Dependent pays for any excluded Prescription Drug Product or other product or service will not be included in calculating any applicable plan Out-of-Pocket Maximum. You are responsible for paying 100% of the cost (the amount the Pharmacy charges you) for any excluded Prescription Drug Product or other product.

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Exclusions

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

- coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.
- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products dispensed outside the jurisdiction of the United States, except as required for emergency or Urgent Care treatment.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- medications used for cosmetic purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth and fade cream products.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.
- Prescription Drug Products used for the treatment of male or female sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, hypoactive sexual desire disorder and decreased libido.
- any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).
- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
- medications used for travel prophylaxis, immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions unless specifically identified on the Prescription Drug List.
- smoking cessation medications except those required by federal law to be covered as Preventive Care Medications.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- medications that are experimental, investigational or unproven as described under the "General Exclusion and Limitations" section of your plan's certificate.

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Reimbursement/Filing a Claim

Retail Pharmacy

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

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

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- 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 your 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 Cigna. 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. Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.
- 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 plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to 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: macromastia or gynecomastia surgeries; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- 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 six months of an accident.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long-term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Care Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Care Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth

announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- 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 corrective lenses, or the first set of eyeglass lenses and frames and associated services for treatment of keratoconus or following cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- all non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services 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.
- enteral feedings, supplies and specially formulated medical foods that are prescribed and non-prescribed, except for infant formula needed for the treatment of inborn errors of metabolism.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- massage therapy.

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 plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.

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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.

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

The amount of charges considered for payment under the Plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

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

Order of Benefit Determination Rules

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

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan

which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child; and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

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

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

Effect on the Benefits of This Plan

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

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

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

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

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

Recovery of Excess Benefits

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

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

Right to Receive and Release Information

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

Coordination of Benefits with Medicare

If you, your spouse, or your Dependent are covered under this Plan and qualify for Medicare, federal law determines which Plan is the primary payer and which is the secondary payer. The primary payer always determines covered benefits first, without considering what any other coverage will pay. The secondary payer determines its coverage only after the Primary Plan has completed its determination.

When Medicare is the Primary Payer

Medicare will be the primary payer and this Plan will be the secondary payer, even if you don't elect to enroll in Medicare or you receive services from a provider who does not accept Medicare payments, in the following situations:

- COBRA or State Continuation: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to COBRA or state continuation of coverage.
- Retirement or Termination of Employment: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to your retirement or termination of employment.
- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has fewer than 100 employees.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has fewer than 20 employees.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan will be the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

When This Plan is the Primary Payer

This Plan will be the primary payer and Medicare will be the secondary payer in the following situations:

- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has 100 or more employees.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has 20 or more employees.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan is the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

Domestic Partners

Under federal law, when Medicare coverage is due to age, Medicare is always the primary payer and this Plan is the secondary payer for a person covered under this Plan as a Domestic Partner. However, when Medicare coverage is due to disability, the Disability payer explanations above will apply.

IMPORTANT: If you, your spouse, or your Dependent do not elect to enroll in Medicare Parts A and/or B when first eligible, or you receive services from a provider who does not accept Medicare payments, this Plan will calculate payment based on what should have been paid by Medicare as the primary payer if the person had been enrolled or had received services from a provider who accepts Medicare payments. A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective.

Failure to Enroll in Medicare

If you, your spouse, or your Dependent do not enroll in Medicare Parts A and/or B during the person's initial Medicare enrollment period, or the person opts out of coverage, the person may be subject to Medicare late enrollment penalties, which can cause a delay in coverage and result in higher Medicare premiums when the person does enroll. It can also result in a reduction in coverage under Medicare Parts A and B. If you are planning to retire or terminate employment and you will be eligible for COBRA, state Continuation, or retiree coverage under this Plan, you should enroll in Medicare before you terminate employment to avoid penalties and to receive the maximum coverage under Medicare. Please consult Medicare or the Social Security Administration for more information.

Assistance with Medicare Questions

For more information on Medicare's rules and regulations, contact Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. You may also contact the Social Security Administration toll-free at 1-800-772-1213, at www.ssa.gov, or call your local Social Security Administration office.

HC-COB275 01-21

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,")

for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.

- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government 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.

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, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

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 the pursuit of its right of recovery. The plan's 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 recovery rights by providing requested information.

This provision will not apply to benefits payable under the Pennsylvania Motor Vehicle Finance Responsibility Law or under Act III, Health Care Services Malpractice Act of Pennsylvania.

HC-SUB98 10-16

Payment of Benefits

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, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

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

Even if the payment of healthcare benefits to a Non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your 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 one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

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

Calculation of Covered Expenses

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

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

HC-POB132 01-19

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

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

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

Injury or Sickness

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

Dependents

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

- the date your insurance ceases.

- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is cancelled.

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

HC-TRM128 M 12-17

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 01-11

Federal Requirements

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

HC-FED1 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.

Notice Regarding Pharmacy Directories and Pharmacy Networks

A list of network pharmacies is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of pharmacies 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 not be considered a Late Entrant for Dependent Insurance.

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

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

HC-FED4 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). 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.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - 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 a current or former Employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the Employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an Employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

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

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

HC-FED96 04-17

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 your Employer agrees, and you meet the criteria shown in the following Sections B through H and enroll for or change coverage within the time period established by your Employer.

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 benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

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

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. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. 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 group 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.

HC-FED95 04-17

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent 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 the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67 09-14

Coverage for Maternity Hospital Stay

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

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

HC-FED11 10-10

Women's Health and Cancer Rights Act (WHCRA)

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

Continuation of Health Insurance During Leave

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

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

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

Reinstatement of Canceled Insurance Following Leave

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

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 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 and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

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

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

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

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

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

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

Reinstatement of Benefits (applicable to all coverages)

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

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

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 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 Certificate 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 Certificate, 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 Certificate, 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.

HC-FED104 01-19

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

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

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

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

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary 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.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

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

Disability Extension

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

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

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

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

30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

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

Medicare Extension for Your Dependents

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

Termination of COBRA Continuation

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

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

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

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

Employer's Notification Requirements

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

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

How to Elect COBRA Continuation Coverage

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

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

continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within 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 Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

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

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

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

Newly Acquired Dependents

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

COBRA Continuation for Retirees Following Employer's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your

covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

Conversion Available Following Continuation

If your or your Dependents' COBRA continuation ends due to the expiration of the maximum 18-, 29- or 36-month period, whichever applies, you and/or your Dependents may be entitled to convert to the coverage in accordance with the Medical Conversion benefit then available to Employees and the Dependents. Please refer to the section titled "Conversion Privilege" for more information.

Interaction With Other Continuation Benefits

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

HC-FED66 07-14

ERISA Required Information

The name of the Plan is:

Latitude AI, LLC Health & Welfare Plan

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

Latitude AI, LLC
2545 Railroad Street
Pittsburgh, PA 15222
412-904-1216

Employer Identification Number (EIN):	Plan Number:
921130676	501

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

Employer named above

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

Employer named above

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 Plan's fiscal year ends on 08/31.

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

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the

policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

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

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 the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, 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 05-15

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 care 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, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write us at the toll-free number on your 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 your benefit plan will abide by the decision of the IRO.

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

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

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled

to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a), if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health 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.

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

Relevant Information

Relevant Information is any document, record or other information 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

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

HC-FED82V1 03-14

Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

HC-SPP4 04-10
V1

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-AAR1 01-17

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

Ambulance

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

HC-DFS1406 01-20

Ancillary Charge

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

HC-DFS1562 01-21

Biologic

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

HC-DFS840 10-16

Biosimilar

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

HC-DFS841 10-16

Brand Drug

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

HC-DFS842 10-16

Business Decision Team

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

HC-DFS1563 10-21

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

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:

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

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

The term child means a child born to you or a child legally adopted by you including that child, from the date of placement in your home, regardless of whether the adoption has become final. It also includes a stepchild or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

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

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

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

HC-DFS1007 10-16

Designated Pharmacy

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

HC-DFS1564 01-21

Domestic Partner

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

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two

of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;

- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

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

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

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

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

HC-DFS47 04-10
V1

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-DFS1414 01-20

Employee

The term Employee means a full or part-time salaried exempt Employee of the Employer who is currently in Active Service. The term does not include Employees who are temporary or who normally work less than 30 hours a week for the Employer.

HC-DFS1094 M 12-17

Employer

The term Employer means the policyholder and those affiliated Employers whose Employees are covered under this Policy.

HC-DFS1566 01-21

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.

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

HC-DFS1407 01-20

Generic Drug

A Prescription Drug Product that Cigna identifies as a Generic Drug product at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics (including Biosimilars) as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the plan. A Biosimilar may be classified as a Generic Drug for the purposes of benefits under the plan even if it is identified as a "brand name" drug by the manufacturer, Pharmacy or your Physician.

HC-DFS846 10-16

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

HC-DFS1415 01-20
V2

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 Drug Product

A Prescription Drug Product that is prescribed for use over an extended period of time for the treatment of chronic or long-term conditions such as asthma, hypertension, diabetes and heart disease, and is identified principally based on consideration of available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source and clinical factors. For the purposes of benefits, the list of your plan's Maintenance Drug Products does not include compounded medications, Specialty Prescription Drug Products or Prescription Drug Products, such as certain narcotics that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or Refill under applicable federal or state law. You may determine whether a drug is a Maintenance Medication by calling member services at the telephone number on your ID card.

HC-DFS847 10-16

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 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 schedule that 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-DFS1196 01-19

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 Professional 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-DFS1410 01-20

Medically Necessary/Medical Necessity

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

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

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

HC-DFS1411 01-20

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

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

HC-DFS1409 01-20

Network Pharmacy

A retail or home delivery Pharmacy that has:

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

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

HC-DFS1198 01-19

New Prescription Drug Product

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

HC-DFS1568 01-21

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

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.

HC-DFS1412 01-20

Other Health Professional

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-DFS1413 01-20

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

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

HC-DFS851 10-16

Pharmacy & Therapeutics (P&T) Committee

A committee comprised of Physicians and an independent pharmacist that represent a range of clinical specialties. The

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

HC-DFS1570 01-21

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 Charge

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

HC-DFS1191 01-19

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) into coverage tiers. This list is 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. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.

HC-DFS1571 01-21

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, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips;
- Insulin
- Injection aids
- Pre-filled insulin pens and cartridges
- Pharmacological agents for controlling blood sugar
- 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-DFS1049 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 Care Medications

The Prescription Drug Products or other medications (including over-the-counter medications) designated as

payable by the plan at 100% of the cost (without application of any Deductible, Copayment or Coinsurance) as required by applicable law under any of the following:

- 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.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

A written prescription is required to process a claim for a Preventive Care Medication. You may determine whether a drug is a Preventive Care Medication through the internet website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-DFS857 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

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

Room and Board

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

HC-DFS1408 01-20

Sickness – For Medical Insurance

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

HC-DFS279 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 Prescription Drug Product or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Prescription Drug Product or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug Product or Medical Pharmaceutical has a high acquisition cost; and, whether the Prescription Drug Product or Medical Pharmaceutical is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug Product or Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, or by tier assignment or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

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
V1

Therapeutic Alternative

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

HC-DFS859 10-16

Therapeutic Equivalent

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

HC-DFS860 10-16

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
V1

Usual and Customary (U&C) Charge

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

HC-DFS861 10-16

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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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $2,000/individual - employee only or $4,000/family maximum For out-of-network providers: $2,000/individual - employee only or $4,000/family maximum Combined medical/behavioral and pharmacy deductible Deductible per individual applies when the employee is the only individual covered under the plan.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, out-of-network immunizations through age 20.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $4,000/individual - employee only or $6,000/family maximum (no more than $4,000 per individual - within a family) For out-of-network providers: $4,000/individual - employee only or $6,000/family maximum (no more than $4,000 per individual - within a family) Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge/visit	20% coinsurance	None
	Specialist visit	No charge/visit	20% coinsurance	None
	Preventive care/ screening/ immunization	No charge/visit** No charge/screening** No charge/immunizations** No charge/immunizations** **Deductible does not apply	20% coinsurance/visit 20% coinsurance/ screening 20% coinsurance/ immunizations** 20% coinsurance/ immunizations **Deductible does not apply	None None Coverage birth through age 20 Coverage age 21 and older You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	$10 copay/prescription (retail 30 days), $20 copay/prescription (retail & home delivery 90 days)	40% coinsurance/prescription (retail); Not covered (home delivery)	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail) and 90 days (home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	$40 copay/prescription (retail 30 days), $80 copay/prescription (retail & home delivery 90 days)	40% coinsurance/prescription (retail); Not covered (home delivery)	
	Non-preferred brand drugs (Tier 3)	$75 copay/prescription (retail 30 days), $150 copay/prescription (retail & home delivery 90 days)	40% coinsurance/prescription (retail); Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share and deductible.
	Emergency medical transportation	No charge	No charge	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	No charge/visit	No charge/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	50% penalty for no out-of-network precertification.
	Physician/surgeon fees	No charge	20% coinsurance	50% penalty for no out-of-network precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge/office visit No charge/all other services	20% coinsurance/office visit 20% coinsurance/all other services	50% penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.). Includes medical services for MH/SA diagnoses.
	Inpatient services	No charge	20% coinsurance	50% penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	No charge	20% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Coverage is limited to 60 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	No charge/PCP visit No charge/Specialist visit	20% coinsurance/PCP visit 20% coinsurance/ Specialist visit	Coverage is limited to annual max of: 60 days for Rehabilitation services; 36 days for Cardiac rehab services; 60 days for Chiropractic care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	No charge/PCP visit No charge/Specialist visit	20% coinsurance/PCP visit 20% coinsurance/ Specialist visit	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	No charge	20% coinsurance	50% penalty for no out-of-network precertification. Coverage is limited to 100 days annual max.
	Durable medical equipment	No charge	20% coinsurance	None
	Hospice services	No charge/inpatient services No charge/outpatient services	20% coinsurance/inpatient services 20% coinsurance/outpatient services	50% penalty for failure to precertify out-of-network inpatient hospice services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (12 days)
- Chiropractic care (60 days)
- Infertility treatment

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Pennsylvania Insurance Department at 1-877-881-6388 and Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or Pennsylvania Insurance Department at 1-877-881-6388. Additionally, a consumer assistance program can help you file your appeal. Contact: Pennsylvania Consumer Assistance Program at (877) 881-6388.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$2,030

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	$2,440

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,000

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: HSA **Ben Ver:** 28 **Plan ID:** 17394994

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DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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 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
PO 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, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

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

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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 711 را شماره‌گیری کنید).

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BENEFIT SUMMARY

Cigna Health and Life Insurance Co.
For - Latitude AI LLC
Choice Fund Open Access Plus HSA Plan
HSA
Effective - 01/01/2024

Selection of a Primary Care Provider - your plan may require or allow 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. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. 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.

Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care 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.

A notice for Missouri residents required by RSMo 376.1199.6: This plan has purchased an optional rider to cover elective abortions. The enrollee has the right to exclude, and not pay for, coverage for elective abortions if such coverage is contrary to the enrollee's moral, ethical or religious beliefs.

A notice for Texas residents per Tex. Ins. Code §1218.001 et.al.: This plan has purchased an optional rider to cover elective abortions. The enrollee has the right to exclude from their plan, and not pay for, coverage for elective abortions.

Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses.

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.	
Plan Coinsurance	Plan pays 100%	Plan pays 80%
Maximum Reimbursable Charge	Not Applicable	110%

Plan Highlights	In-Network	Out-of-Network
Plan Deductible	Individual - Employee Only: $2,000 Family Maximum: $4,000	Individual - Employee Only: $2,000 Family Maximum: $4,000

- The amount you pay for all covered expenses counts toward both your in-network and out-of-network deductibles.
- Plan deductible always applies before any benefit copay/deductible or coinsurance.
- Plan deductible does not apply to in-network preventive services.
- 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.
- This plan includes a combined Medical/Pharmacy plan deductible.

Note: Services where plan deductible applies are noted with a caret (^).

Plan Out-of-Pocket Maximum	Individual - Employee Only: $4,000 Individual - within a Family: $4,000 Family Maximum: $6,000	Individual - Employee Only: $4,000 Individual - within a Family: $4,000 Family Maximum: $6,000

- The amount you pay for all covered expenses counts towards both your in-network and out-of-network out-of-pocket maximums.
- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	Plan pays 100% ^	Plan pays 80% ^
Specialty Care Physician Services/Office Visit	Plan pays 100% ^	Plan pays 80% ^
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit	Plan pays 80% ^
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Virtual Care		
Dedicated Virtual Providers - MDLIVE		
MDLIVE Urgent Virtual Care Services	Plan pays 100% ^	Not Covered
MDLIVE Primary Care Services	Plan pays 100% ^	Not Covered
MDLIVE Specialty Care Services	Plan pays 100% ^	Not Covered
• Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care. • Lab services supporting a virtual visit must be obtained through dedicated labs. • Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.		
Virtual Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	Plan pays 100% ^	Plan pays 80% ^
Specialty Care Physician Services/Office Visit	Plan pays 100% ^	Plan pays 80% ^
• Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services). • Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting. **NOTE:** Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
Convenience Care Clinic		
Convenience Care Clinic	Plan pays 100% ^	Plan pays 80% ^
Preventive Care		
Preventive Care	Plan pays 100%	PCP: Plan pays 80% ^ Specialist: Plan pays 80% ^
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit. • Annual Limit: Unlimited		
Immunizations Birth through age 20 Ages 21 and older	 Plan pays 100% Plan pays 100%	 PCP: Plan pays 80% Specialist: Plan pays 80% PCP: Plan pays 80% ^ Specialist: Plan pays 80% ^
Mammogram, PAP, and PSA Tests	Plan pays 100%	Covered same as other x-ray and lab services, based on Place of Service
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service.		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Inpatient		
Inpatient Hospital Facility Services	Plan pays 100% ^	Plan pays 80% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs		
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100% ^	Plan pays 80% ^
Inpatient Professional Services	Plan pays 100% ^	Plan pays 80% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		
Outpatient		
Outpatient Facility Services	Plan pays 100% ^	Plan pays 80% ^
Outpatient Professional Services	Plan pays 100% ^	Plan pays 80% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		
Emergency Services		
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. • Per visit copay is waived if admitted.	$150 copay, and plan pays 100% ^	$150 copay, and plan pays 100% ^
Urgent Care Facility • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	Plan pays 100% ^	Plan pays 100% ^
Ambulance	Plan pays 100% ^	Plan pays 100% ^
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 100 days	Plan pays 100% ^	Plan pays 80% ^
Laboratory Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 100% ^	Plan pays 80% ^
Outpatient Facility	Plan pays 100% ^	Plan pays 80% ^
Radiology Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 100% ^	Plan pays 80% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 100% ^	Plan pays 80% ^
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Outpatient Therapy Services		
Outpatient Therapy Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limits: • All Therapies Combined - Includes Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 60 days • Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.		
Chiropractic Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limit: • Chiropractic Care - 60 days		
Cardiac Rehabilitation Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limit: • Cardiac Rehabilitation - 36 days		
Hospice		
Inpatient Facilities	Plan pays 100% ^	Plan pays 80% ^
Outpatient Services	Plan pays 100% ^	Plan pays 80% ^
Note: Includes Bereavement counseling provided as part of a hospice program.		
Bereavement Counseling (for services not provided as part of a hospice program)		
Services Provided by a Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Medical Pharmaceutical Drugs		
Cigna Pathwell Specialty℠ Medical Pharmaceuticals	**Cigna Pathwell Specialty℠ Network:** Plan pays 100% ^ **All other medical network providers:** Not Covered	Not Covered
Other Medical Pharmaceuticals	Plan pays 100% ^	Not Covered
Note: This benefit only applies to the cost of Medical Pharmaceutical drugs administered. Related Facility, Office Visit or Professional charges are covered according to the plan design.		
Maternity		
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 100% ^	Plan pays 80% ^
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Delivery - Facility (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Abortion		
Abortion Services Rider	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Note: Elective and non-elective procedures		
Family Planning		
Women's Services	Plan pays 100%	Coverage varies based on Place of Service
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)		
Men's Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
Infertility		
Infertility Treatment	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. • Lifetime Maximum: Unlimited		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Other Health Care Facilities/Services		
Home Health Care • Annual Limit: 60 days (The limit is not applicable to mental health and substance use disorder conditions.) • 16 hour maximum per day **Note:** Includes outpatient private duty nursing when approved as medically necessary	Plan pays 100% ^	Plan pays 80% ^
Organ Transplants		
Inpatient Hospital Facility Services		
LifeSOURCE Facility	Plan pays 100% ^	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Inpatient Professional Services		
LifeSOURCE Facility	Plan pays 100% ^	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Professional benefit	Covered same as plan's Inpatient Professional benefit
• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: After the plan deductible is met, Unlimited maximum per Transplant per Lifetime		
Durable Medical Equipment • Annual Limit: Unlimited	Plan pays 100% ^	Plan pays 80% ^
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan pays 100%	Plan pays 80% ^
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	Plan pays 100% ^	Plan pays 80% ^
Temporomandibular Joint Disorder (TMJ) • Unlimited Non-Surgical lifetime maximum **Note:** Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Routine Foot Care **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	Not Covered	Not Covered
Acupuncture • Annual Limit: 12 days	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.		
Mental Health and Substance Use Disorder		
Inpatient Mental Health	Plan pays 100% ^	Plan pays 80% ^
Outpatient Mental Health – Physician's Office	Plan pays 100% ^	Plan pays 80% ^
Outpatient Mental Health – All Other Services	Plan pays 100% ^	Plan pays 80% ^
Inpatient Substance Use Disorder	Plan pays 100% ^	Plan pays 80% ^
Outpatient Substance Use Disorder – Physician's Office	Plan pays 100% ^	Plan pays 80% ^
Outpatient Substance Use Disorder – All Other Services	Plan pays 100% ^	Plan pays 80% ^

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.
- Services are paid at 100% after you reach your out-of-pocket maximum.

Important Note on Mental Health and Substance Use Disorder Coverage: Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled "Mental Health and Substance Use Disorder."

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Cigna Total Behavioral Health - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- inMynd℠ program - a comprehensive, holistic solution to help recognize and find resources to treat behavioral health conditions.

Pharmacy	In-Network	Out-of-Network
Cost Share and Supply		
Cigna Pharmacy Plus Cost Share • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply (except Specialty up to 90-day supply)	**Retail (per 30-day supply):** Generic: You pay $10 ^ Preferred Brand: You pay $40 ^ Non-Preferred Brand: You pay $75 ^ **Retail and Home Delivery (per 90-day supply):** Generic: You pay $20 ^ Preferred Brand: You pay $80 ^ Non-Preferred Brand: You pay $150 ^	**Retail:** You pay 40% ^ Your plan pays 60% ^ **Home Delivery:** Not Covered

- Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies.
- Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or network home delivery pharmacy. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or network home delivery pharmacy to be covered by the plan.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When patient requests brand drug, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW).
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.
- Your pharmacy benefits share an annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met.
- Specialty Drugs provided at Home Delivery at the Retail (per 30-day supply) cost share.

Drugs Covered

Prescription Drug List:
Your Cigna Value Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. Some of the more expensive drugs are excluded when there are less expensive alternatives. To check which drugs are included in your plan, please log on to myCigna.com.
Some highlights:

- Coverage includes Self Administered injectables and optional injectable drugs – but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Oral Fertility drugs are covered.

Pharmacy Program Information

Pharmacy Clinical Management: Essential

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

Patient Assurance Program

Your plan includes the Patient Assurance Program, which waives the deductible and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally:

- Any amount you pay for these medications only count toward meeting your out-of-pocket maximum.
- Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum.

Additional Information

Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Comprehensive Oncology Program • Care Management outreach • Case Management	Included
Health Advisor - A Support for healthy and at-risk individuals to help them stay healthy • Health Assessments • Health and Wellness Coaching • Gaps in Care Coaching • Treatment Decision Support • Educate and Refer	Included

Additional Information

Healthy Pregnancies/Healthy Babies • Care Management outreach • Maternity Case Management • Neo-natal Case Management	$150 (1st trimester) / $75 (2nd trimester) - Option 3

Maximum Reimbursable Charge
The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (110%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. 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. Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level as required by applicable state or federal law if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or federal law.

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

Medicare Coordination
In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

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.

One Guide
Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

Additional Information

Pre-Certification - Continued Stay Review – Basic Care Standard Management Inpatient - required for all inpatient admissions
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 50% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

Pre-Certification - Basic Care Standard Management Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 50% penalty applied to outpatient procedures charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures reviewed by Cigna Healthcare and not certified.

Pre-Existing Condition Limitation (PCL) does not apply.

Your Health First - 200
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Place of Service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- 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 your 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 Cigna. 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;

Exclusions

- 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 plan; or
- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to 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: macromastia or gynecomastia surgeries; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- 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 six months of an accident.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long-term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Care Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Care Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.

Exclusions

- 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 corrective lenses, or the first set of eyeglass lenses and frames and associated services for treatment of keratoconus or following cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services 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.
- Enteral feedings, supplies and specialty formulated medical foods that are prescribed and non-prescribed, except for infant formula needed for the treatment of inborn errors of metabolism.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit
- Massage therapy.

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate, service agreement or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Care Solutions, Inc., Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation.

EHB State: PA

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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 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
PO 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, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

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

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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 711 را شماره‌گیری کنید).

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Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation

EOC #4 - Kaiser Permanente Traditional HMO Plan
Evidence of Coverage for
LATITUDE AI LLC DBA LATITUDE AI

Group ID: 606405 Contract: 1 Version: 11 *EOC* Number: 4

February 1, 2023, through December 31, 2023

Member Services
24 hours a day, seven days a week (except closed holidays)
1-800-464-4000 (TTY users call **711**)
kp.org

coaccum NGF ACA

TABLE OF CONTENTS FOR EOC #4

Cost Share Summary

This "Cost Share Summary" is part of your Evidence of Coverage (*EOC*) and is meant to explain the amount you will pay for covered Services under this plan. It does not provide a full description of your benefits. For a full description of your benefits, including any limitations and exclusions, please read this entire *EOC*, including any amendments, carefully.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Deductibles and Out-of-Pocket Maximums

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

If your Group's plan changes during an Accumulation Period, your deductibles and out-of-pocket maximums may increase or decrease, which may change the total amount you must accumulate to reach the deductibles or out-of-pocket maximums during that Accumulation Period.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Deductible	None	None	None
Drug Deductible	None	None	None
Plan Out-of-Pocket Maximum ("OOPM")	$1,500	$1,500	$3,000

Cost Share Summary Tables by Benefit

How to read the Cost Share summary tables

Each table below explains the Cost Share for a category of benefits. Specific Services related to the benefit are described in the first column of each table. For a detailed description of coverage for a particular benefit, refer to the same benefit heading in the "Benefits" section of this *EOC*.

- **Copayment / Coinsurance**. This column describes the Cost Share you will pay for Services after you have met your Plan Deductible or Drug Deductible, if applicable. (Please see the "Deductibles and Out-of-Pocket Maximums" section above to determine if your plan includes deductibles.) If the Services are not covered in your plan, this column will read "Not covered." If we provide an Allowance that you can use toward the cost of the Services, this column will include the Allowance.
- **Subject to Deductible**. This column explains whether the Cost Share you pay for Services is subject to a Plan Deductible or Drug Deductible. If the Services are subject to a deductible, you will pay Charges for those Services until you have met your deductible. If the Services are subject to a deductible, there will be a "✓" or "D" in this column, depending on which deductible applies ("✓" for Plan Deductible, "D" for Drug Deductible). If the Services do not apply to a deductible, or if your plan does not include a deductible, this column will be blank. For a more detailed explanation of deductibles, refer to "Plan Deductible" and "Drug Deductible" in the "Benefits" section of this *EOC*.
- **Applies to OOPM**. This column explains whether the Cost Share you pay for Services counts toward the Plan Out-of-Pocket Maximum ("OOPM") after you have met any applicable deductible. If the Services count toward the Plan OOPM, there will be a "✓" in this column. If the Services do not count toward the Plan OOPM, this column will be blank. For a more detailed explanation of the Plan OOPM, refer to "Plan Out-of-Pocket Maximum" heading in the "Benefits" section of this *EOC*.

Administered drugs and products

Description of Administered Drugs and Products Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Whole blood, red blood cells, plasma, and platelets	No charge		✓
Allergy antigens (including administration)	No charge		✓
Cancer chemotherapy drugs and adjuncts	No charge		✓
Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood	No charge		✓
All other administered drugs and products	No charge		✓
Drugs and products administered to you during a home visit	No charge		✓

Ambulance Services

Description of Ambulance Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency ambulance Services	$50 per trip		✓
Nonemergency ambulance and psychiatric transport van Services	$50 per trip		✓

Behavioral health treatment for autism spectrum disorder

Description of Behavioral Health Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Covered Services	No charge		✓

Dialysis care

Description of Dialysis Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Equipment and supplies for home hemodialysis and home peritoneal dialysis	No charge		✓
One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment	No charge		✓

Description of Dialysis Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hemodialysis and peritoneal dialysis treatment at a Plan Facility	$10 per visit		✓

Durable Medical Equipment ("DME") for home use

Description of DME Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Blood glucose monitors for diabetes blood testing and their supplies	20% Coinsurance		✓
Peak flow meters	20% Coinsurance		✓
Insulin pumps and supplies to operate the pump	20% Coinsurance		✓
Other Base DME Items as described in this *EOC*	20% Coinsurance		✓
Supplemental DME items as described in this *EOC*	20% Coinsurance		
Retail-grade breast pumps	No charge		✓
Hospital-grade breast pumps	No charge		✓

Emergency Services and Urgent Care

Description of Emergency Services and Urgent Care	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency department visits	$100 per visit		✓
Urgent Care visits	$10 per visit		✓

Note: If you are admitted to the hospital as an inpatient from the emergency department, the emergency department visits Cost Share above does not apply. Instead, the Services you received in the emergency department, including any observation stay, if applicable, will be considered part of your hospital inpatient stay. For the Cost Share for inpatient Services, refer to "Hospital inpatient Services" in this "Cost Share Summary." The emergency department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Fertility Services

Diagnosis and treatment of infertility

Description of Diagnosis and Treatment of Infertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	$10 per visit		
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	$10 per procedure		
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	$10 per procedure		
Outpatient imaging	No charge		
Outpatient laboratory	No charge		
Outpatient administered drugs	No charge		
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	No charge		

Artificial insemination

Description of Artificial Insemination Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	$10 per visit		
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	$10 per procedure		
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	$10 per procedure		
Outpatient imaging	No charge		

Description of Artificial Insemination Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient laboratory	No charge		
Outpatient administered drugs	No charge		
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	No charge		

Assisted reproductive technology ("ART") Services

Description of ART Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Assisted reproductive technology ("ART") Services such as invitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), or zygote intrafallopian transfer ("ZIFT")	Not covered		

Health education

Description of Health Education Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Covered health education programs, which may include programs provided online and counseling over the phone	No charge		✓
Individual counseling during an office visit related to tobacco cessation	No charge		✓
Individual counseling during an office visit related to diabetes management	No charge		✓
Other covered individual counseling when the office visit is solely for health education	No charge		✓
Covered health education materials	No charge		✓

Hearing Services

Description of Hearing Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hearing exams with an audiologist to determine the need for hearing correction	$10 per visit		✓

Description of Hearing Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Physician Specialist Visits to diagnose and treat hearing problems	$10 per visit		✓
Hearing aids, including, fitting, counseling, adjustment, cleaning, and inspection	Not covered		

Home health care

Description of Home Health Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Home health care Services (100 visits per Accumulation Period)	No charge		✓

Hospice care

Description of Hospice Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospice Services	No charge		✓

Hospital inpatient Services

Description of Hospital Inpatient Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospital inpatient stays	No charge		✓

Injury to teeth

Description of Injury to Teeth Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Accidental injury to teeth	Not covered		

Mental health Services

Description of Mental Health Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient mental health hospital stays	No charge		✓
Individual mental health evaluation and treatment	$10 per visit		✓

Description of Mental Health Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Group mental health treatment	$5 per visit		✓
Partial hospitalization	No charge		✓
Other intensive psychiatric treatment programs	No charge		✓
Residential mental health treatment Services	No charge		✓

Office visits

Description of Office Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this "Cost Share Summary"	$10 per visit		✓
Physician Specialist Visits that are not described elsewhere in this "Cost Share Summary"	$10 per visit		✓
Group appointments that are not described elsewhere in this "Cost Share Summary"	$5 per visit		✓
Acupuncture Services	$10 per visit		✓

Ostomy and urological supplies

Description of Ostomy and Urological Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Ostomy and urological supplies as described in this *EOC*	No charge		✓

Outpatient imaging, laboratory, and other diagnostic and treatment Services

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans	No charge		✓
Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds	No charge		✓

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Nuclear medicine	No charge		✓
Routine retinal photography screenings	No charge		✓
Routine laboratory tests to monitor the effectiveness of dialysis	No charge		✓
All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)	No charge		✓
Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs)	No charge		✓
Radiation therapy	No charge		✓
Ultraviolet light treatments (including ultraviolet light therapy equipment as described in this *EOC*)	No charge		✓

Outpatient prescription drugs, supplies, and supplements

If the "Cost Share at a Plan Pharmacy" column in this section provides Cost Share for a 30-day supply and your Plan Physician prescribes more than this, you may be able to obtain more than a 30-day supply at one time up to the day supply limit for that drug. Applicable Cost Share will apply. For example, two 30-day copayments may be due when picking up a 60-day prescription, three copayments may be due when picking up a 100-day prescription at the pharmacy.

Most items

Description of Most Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on the generic tier (Tier 1) not described elsewhere in this "Cost Share Summary"	$10 for up to a 30-day supply	$20 for up to a 100-day supply		✓
Items on the brand tier (Tier 2) not described elsewhere in this "Cost Share Summary"	$20 for up to a 30-day supply	$40 for up to a 100-day supply		✓
Items on the specialty tier (Tier 4) not described elsewhere in this "Cost Share Summary"	20% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Base drugs, supplies, and supplements

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Hematopoietic agents for dialysis	No charge for up to a 30-day supply	Not available		✓
Elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge for up to a 30-day supply	Not available		✓
All other items on the generic tier (Tier 1) as described in this *EOC*	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
All other items on the brand tier (Tier 2) as described in this *EOC*	$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
All other items on the specialty tier (Tier 4) as described in this *EOC*	20% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Anticancer drugs and certain critical adjuncts following a diagnosis of cancer

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Oral anticancer drugs on the generic tier (Tier 1)	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on the brand tier (Tier 2)	$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on the specialty tier (Tier 4)	20% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Non-oral anticancer drugs on the generic tier (Tier 1)	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on the brand tier (Tier 2)	$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on the specialty tier (Tier 4)	20% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Home infusion drugs

Description of Home Infusion Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Home infusion drugs	No charge for up to a 30-day supply	Not available		✓
Supplies necessary for administration of home infusion drugs	No charge	No charge		✓

Home infusion drugs are self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion, such as an intravenous or intraspinal-infusion.

Diabetes supplies and amino acid–modified products

Description of Diabetes Supplies and Amino Acid-Modified Products	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)	No charge for up to a 30-day supply	Not available		✓
Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing	No charge for up to a 100-day supply	Not available		✓
Insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear)	$10 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

For drugs related to the treatment of diabetes (for example, insulin), and for continuous insulin delivery devices that use disposable items such as patches or pods, refer to the "Most items" table above. For insulin pumps, refer to the "Durable Medical Equipment ("DME") for home use" table above.

Contraceptive drugs and devices

Description of Contraceptive Drugs and Devices	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
The following hormonal contraceptive items for women on the generic tier (Tier 1) when prescribed by a Plan Provider: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Rings are not available for mail order		✓
The following contraceptive items for women on the generic tier (Tier 1) when prescribed by a Plan Provider: • Spermicide • Sponges	No charge for up to a 100-day supply	Not available		✓
The following hormonal contraceptive items for women on the brand tier (Tier 2) when prescribed by a Plan Provider: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Rings are not available for mail order		✓
The following contraceptive items for women on the brand tier (Tier 2) when prescribed by a Plan Provider: • Spermicide • Sponges	No charge for up to a 100-day supply	Not available		✓
Emergency contraception	No charge	Not available		✓
Diaphragms, cervical caps, and up to a 30-day supply of condoms prescribed for women	No charge	Not available		✓

Certain preventive items

Description of Certain Preventive Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on our Preventive Services list on our website at **kp.org/prevention** when prescribed by a Plan Provider	No charge for up to a 100-day supply	Not available		✓

Fertility and sexual dysfunction drugs

Description of Fertility and Sexual Dysfunction Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Drugs on the generic tier (Tier 1) prescribed to treat infertility or in connection with covered artificial insemination Services	$10 for up to a 30-day supply	$20 for up to a 100-day supply		
Drugs on the brand and specialty tiers (Tier 2 and Tier 4) prescribed to treat infertility or in connection with covered artificial insemination Services	$20 for up to a 30-day supply	$40 for up to a 100-day supply		
Drugs on the generic tier (Tier 1) prescribed in connection with covered assisted reproductive technology (“ART”) Services	Not covered	Not covered		
Drugs on the brand and specialty tiers (Tier 2 and Tier 4) prescribed in connection with covered assisted reproductive technology (“ART”) Services	Not covered	Not covered		
Drugs on the generic tier (Tier 1) prescribed for sexual dysfunction disorders	50% Coinsurance (not to exceed $50) for up to a 100-day supply	50% Coinsurance (not to exceed $50) for up to a 100-day supply		✓
Drugs on the brand and specialty tiers (Tier 2 and Tier 4) prescribed for sexual dysfunction disorders	50% Coinsurance (not to exceed $100) for up to a 100-day supply	50% Coinsurance (not to exceed $100) for up to a 100-day supply		✓

Outpatient surgery and outpatient procedures

Description of Outpatient Surgery and Outpatient Procedure Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	$10 per procedure		✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	$10 per procedure		✓

Preventive Services

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine physical exams, including well-woman, postpartum follow-up, and preventive exams for Members age 2 and older	No charge		✓
Well-child preventive exams for Members through age 23 months	No charge		✓
Normal series of regularly scheduled preventive prenatal care exams after confirmation of pregnancy	No charge		✓
Immunizations (including the vaccine) administered to you in a Plan Medical Office	No charge		✓
Tuberculosis skin tests	No charge		✓
Screening and counseling Services when provided during a routine physical exam or a well-child preventive exam, such as obesity counseling, routine vision and hearing screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays	No charge		✓
Screening colonoscopies	No charge		✓
Screening flexible sigmoidoscopies	No charge		✓
Routine imaging screenings such as mammograms	No charge		✓
Bone density CT scans	No charge		✓

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Bone density DEXA scans	No charge		✓
Routine laboratory tests and screenings, such as cancer screening tests, sexually transmitted infection ("STI") tests, cholesterol screening tests, and glucose tolerance tests	No charge		✓
Other laboratory screening tests, such as fecal occult blood tests and hepatitis B screening tests	No charge		✓

Prosthetic and orthotic devices

Description of Prosthetic and Orthotic Device Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Internally implanted prosthetic and orthotic devices as described in this *EOC*	No charge		✓
External prosthetic and orthotic devices as described in this *EOC*	No charge		✓
Supplemental prosthetic and orthotic devices as described in this *EOC*	No charge		✓

Rehabilitative and habilitative Services

Description of Rehabilitative and Habilitative Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual outpatient physical, occupational, and speech therapy	$10 per visit		✓
Group outpatient physical, occupational, and speech therapy	$5 per visit		✓
Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program	$10 per day		✓

Reproductive Health Services

Family planning Services

Description of Family Planning Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Family planning counseling	No charge		✓

Description of Family Planning Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") and office visits related to their insertion, removal, and management when provided to prevent pregnancy	No charge		✓
Female sterilization procedures if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge		✓
All other female sterilization procedures	No charge		✓
Male sterilization procedures if performed in an outpatient or ambulatory surgery center or in a hospital operating room	$10 per procedure		✓
All other male sterilization procedures	$10 per visit		✓

Abortion and abortion-related Services

Description of abortion and abortion-related Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Surgical abortion	No charge		✓
Prescription drugs, in accord with our drug formulary guidelines	No charge		✓
Other abortion-related Services	No charge		✓

Skilled nursing facility care

Description of Skilled Nursing Facility Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Skilled nursing facility Services up to 100 days per benefit period*	No charge		✓

*A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

Substance use disorder treatment

Description of Substance Use Disorder Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient detoxification	No charge		✓
Individual substance use disorder evaluation and treatment	$10 per visit		✓
Group substance use disorder treatment	$5 per visit		✓
Intensive outpatient and day-treatment programs	No charge		✓
Residential substance use disorder treatment	No charge		✓

Telehealth visits

Interactive video visits

Description of Interactive Video Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		✓
Physician Specialist Visits	No charge		✓

Scheduled telephone visits

Description of Scheduled Telephone Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		✓
Physician Specialist Visits	No charge		✓

Vision Services for Adult Members

Description of Vision Services for Adult Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$10 per visit		✓

Description of Vision Services for Adult Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$10 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Low vision devices (including fitting and dispensing)	Not covered		

Vision Services for Pediatric Members

Description of Vision Services for Pediatric Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$10 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$10 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Low vision devices (including fitting and dispensing)	Not covered		

Introduction

This *Evidence of Coverage* (*"EOC"*) describes the health care coverage of "Kaiser Permanente Traditional HMO Plan" provided under the *Group Agreement* (*"Agreement"*) between Kaiser Foundation Health Plan, Inc. ("Health Plan") and the entity with which Health Plan has entered into the *Agreement* (your "Group").

This *EOC* is part of the *Agreement* between Health Plan and your Group. The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

Once enrolled in other coverage made available through Health Plan, that other plan's evidence of coverage cannot be cancelled without cancelling coverage under this *EOC*, unless the change is made during open enrollment or a special enrollment period.

For benefits provided under any other program offered by your Group (for example, workers compensation benefits), refer to your Group's materials.

In this *EOC*, Health Plan is sometimes referred to as "we" or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*; please see the "Definitions" section for terms you should know.

It is important to familiarize yourself with your coverage by reading this *EOC* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

About Kaiser Permanente

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY GET HEALTH CARE.

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call your "Home Region." The coverage information in this *EOC* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care as described in "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section.

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care. Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*. Plus, our health education programs offer you great ways to protect and improve your health.

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section

Term of this *EOC*

This *EOC* is for the period February 1, 2023, through December 31, 2023, unless amended. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended.

Definitions

Some terms have special meaning in this *EOC*. When we use a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this

"Definitions" section have special meaning when capitalized and used in any section of this *EOC*.

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable), out-of-pocket maximums, and benefit limits. For example, the Accumulation Period may be a calendar year or contract year. The Accumulation Period for this *EOC* is from January 1 through December 31.

Allowance: A specified amount that you can use toward the purchase price of an item. If the price of the items you select exceeds the Allowance, you will pay the amount in excess of the Allowance (and that payment will not apply toward any deductible or out-of-pocket maximum).

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC*. If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage.

Charges: "Charges" means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract your Cost Share

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *EOC*.

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC*.

Note: The dollar amount of the Copayment can be $0 (no charge).

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Disclosure Form ("DF"): A summary of coverage for prospective Members. For some products, the DF is combined with the evidence of coverage.

Drug Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain drugs, supplies, and supplements before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn whether your coverage includes a Drug Deductible, the Services that are subject to the Drug Deductible, and the Drug Deductible amount.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that you reasonably believed that the absence of immediate medical attention would result in any of the following:

- Placing the person's health (or, with respect to a pregnant person, the health of the pregnant person or unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to themself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Emergency Services: All of the following with respect to an Emergency Medical Condition:

- A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post-Stabilization Care and not Emergency Services)

***EOC*:** This *Evidence of Coverage* document, including any amendments, which describes the health care coverage of "Kaiser Permanente Traditional HMO Plan" under Health Plan's *Agreement* with your Group.

Family: A Subscriber and all of their Dependents.

Group: The entity with which Health Plan has entered into the *Agreement* that includes this *EOC*.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. Health Plan is a health care service plan licensed to offer health care coverage by the Department of Managed Health Care. This *EOC* sometimes refers to Health Plan as "we" or "us."

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.

Medical Group: The Permanente Medical Group, Inc., a for-profit professional corporation.

Medically Necessary: For Services related to mental health or substance use disorder treatment, a Service is Medically Necessary if it is addressing your specific needs, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider

For all other Services, a Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Member: A person who is eligible and enrolled under this *EOC*, and for whom we have received applicable Premiums. This *EOC* sometimes refers to a Member as "you."

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists). For Services described under "Dental and Orthodontic Services" in the "Benefits" section, non-physician specialists include dentists and orthodontists.

Non–Plan Hospital: A hospital other than a Plan Hospital.

Non–Plan Physician: A physician other than a Plan Physician.

Non–Plan Provider: A provider other than a Plan Provider.

Non–Plan Psychiatrist: A psychiatrist who is not a Plan Physician.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside our Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn

whether your coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Facility: Any facility listed in the Provider Directory on our website at **kp.org/facilities**. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

Plan Hospital: Any hospital listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call Member Services.

Plan Medical Office: Any medical office listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call Member Services.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Optical Sales Offices. In the directory, Plan Optical Sales Offices may be called "Vision Essentials." The directory is updated periodically. The availability of Plan Optical Sales Offices may change. If you have questions, please call Member Services.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for certain covered Services that you receive in the same Accumulation Period. Refer to the "Cost Share Summary" section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call Member Services.

Plan Physician: Any licensed physician who is an employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Health Plan designates as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the emergency department) after your treating physician determines that this condition is Stabilized.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *EOC*, except that you are responsible for paying Premiums if you have Cal-COBRA coverage. "Full Premiums" means 100 percent of Premiums for all of the coverage issued to each enrolled Member, as set forth in the "Premiums" section of Health Plan's *Agreement* with your Group.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Refer to the Provider Directory on our website at **kp.org/facilities** for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Provider Directory: A directory of Plan Physicians and Plan Facilities in your Home Region. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of

Northern California, Southern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at **kp.org** or call Member Services.

Service Area: The ZIP codes below for each county are in our Service Area:

- All ZIP codes in Alameda County are inside our Northern California Service Area: 94501-02, 94505, 94514, 94536-46, 94550-52, 94555, 94557, 94560, 94566, 94568, 94577-80, 94586-88, 94601-15, 94617-21, 94622-24, 94649, 94659-62, 94666, 94701-10, 94712, 94720, 95377, 95391
- The following ZIP codes in Amador County are inside our Northern California Service Area: 95640, 95669
- All ZIP codes in Contra Costa County are inside our Northern California Service Area: 94505-07, 94509, 94511, 94513-14, 94516-31, 94547-49, 94551, 94553, 94556, 94561, 94563-65, 94569-70, 94572, 94575, 94582-83, 94595-98, 94706-08, 94801-08, 94820, 94850
- The following ZIP codes in El Dorado County are inside our Northern California Service Area: 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Northern California Service Area: 93242, 93602, 93606-07, 93609, 93611-13, 93616, 93618-19, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-30, 93737, 93740-41, 93744-45, 93747, 93750, 93755, 93760-61, 93764-65, 93771-79, 93786, 93790-94, 93844, 93888
- The following ZIP codes in Kings County are inside our Northern California Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Northern California Service Area: 93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, 93720
- All ZIP codes in Marin County are inside our Northern California Service Area: 94901, 94903-04, 94912-15, 94920, 94924-25, 94929-30, 94933, 94937-42, 94945-50, 94956-57, 94960, 94963-66, 94970-71, 94973-74, 94976-79
- The following ZIP codes in Mariposa County are inside our Northern California Service Area: 93601, 93623, 93653
- All ZIP codes in Napa County are inside our Northern California Service Area: 94503, 94508, 94515, 94558-59, 94562, 94567, 94573-74, 94576, 94581, 94599, 95476
- The following ZIP codes in Placer County are inside our Northern California Service Area: 95602-04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95703, 95722, 95736, 95746-47, 95765
- All ZIP codes in Sacramento County are inside our Northern California Service Area: 94203-09, 94211, 94229-30, 94232, 94234-37, 94239-40, 94244-45, 94247-50, 94252, 94254, 94256-59, 94261-63, 94267-69, 94271, 94273-74, 94277-80, 94282-85, 94287-91, 94293-98, 94571, 95608-11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638-39, 95641, 95652, 95655, 95660, 95662, 95670-71, 95673, 95678, 95680, 95683, 95690, 95693, 95741-42, 95757-59, 95763, 95811-38, 95840-43, 95851-53, 95860, 95864-67, 95894, 95899
- All ZIP codes in San Francisco County are inside our Northern California Service Area: 94102-05, 94107-12, 94114-34, 94137, 94139-47, 94151, 94158-61, 94163-64, 94172, 94177, 94188
- All ZIP codes in San Joaquin County are inside our Northern California Service Area: 94514, 95201-15, 95219-20, 95227, 95230-31, 95234, 95236-37, 95240-42, 95253, 95258, 95267, 95269, 95296-97, 95304, 95320, 95330, 95336-37, 95361, 95366, 95376-78, 95385, 95391, 95632, 95686, 95690
- All ZIP codes in San Mateo County are inside our Northern California Service Area: 94002, 94005, 94010-11, 94014-21, 94025-28, 94030, 94037-38, 94044, 94060-66, 94070, 94074, 94080, 94083, 94128, 94303, 94401-04, 94497
- The following ZIP codes in Santa Clara County are inside our Northern California Service Area: 94022-24, 94035, 94039-43, 94085-89, 94301-06, 94309, 94550, 95002, 95008-09, 95011, 95013-15, 95020-21, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95076, 95101, 95103, 95106, 95108-13, 95115-36, 95138-41, 95148, 95150-61, 95164, 95170, 95172-73, 95190-94, 95196
- All ZIP codes in Santa Cruz County are inside our Northern California Service Area: 95001, 95003, 95005-7, 95010, 95017-19, 95033, 95041, 95060-67, 95073, 95076-77
- All ZIP codes in Solano County are inside our Northern California Service Area: 94503, 94510, 94512, 94533-35, 94571, 94585, 94589-92, 95616, 95618, 95620, 95625, 95687-88, 95690, 95694, 95696
- The following ZIP codes in Sonoma County are inside our Northern California Service Area: 94515,

94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-07, 95409, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492

- All ZIP codes in Stanislaus County are inside our Northern California Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322-23, 95326, 95328-29, 95350-58, 95360-61, 95363, 95367-68, 95380-82, 95385-87, 95397
- The following ZIP codes in Sutter County are inside our Northern California Service Area: 95626, 95645, 95659, 95668, 95674, 95676, 95692, 95837
- The following ZIP codes in Tulare County are inside our Northern California Service Area: 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in Yolo County are inside our Northern California Service Area: 95605, 95607, 95612, 95615-18, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
- The following ZIP codes in Yuba County are inside our Northern California Service Area: 95692, 95903, 95961

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area unless that other county is listed above and that ZIP code is also listed for that other county.

If you have a question about whether a ZIP code is in our Service Area, please call Member Services.

Note: We may expand our Service Area at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Postal Service.

Services: Health care services or items ("health care" includes physical health care, mental health care, and substance use disorder treatment), and behavioral health treatment covered under "Behavioral Health Treatment for Autism Spectrum Disorder" in the "Benefits" section.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes the Subscriber's domestic partner. "Domestic partners" are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners).

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is 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 person from the facility. With respect to a pregnant person who is having contractions, when there is inadequate time to safely transfer them to another hospital before delivery (or the transfer may pose a threat to the health or safety of the pregnant person or unborn child), "Stabilize" means to deliver (including the placenta).

Subscriber: A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Surrogacy Arrangement: An arrangement in which an individual agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the individual receives payment for being a surrogate. For the purposes of this *EOC*, "Surrogacy Arrangements" includes all types of surrogacy arrangements, including traditional surrogacy arrangements and gestational surrogacy arrangements.

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Premiums, Eligibility, and Enrollment

Premiums

Your Group is responsible for paying Full Premiums, except that you are responsible for paying Full Premiums

as described in the "Continuation of Membership" section if you have Cal-COBRA coverage under this *EOC*. If you are responsible for any contribution to the Premiums that your Group pays, your Group will tell you the amount, when Premiums are effective, and how to pay your Group (through payroll deduction, for example).

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section, including your Group's eligibility requirements and our Service Area eligibility requirements.

Group eligibility requirements

You must meet your Group's eligibility requirements, such as the minimum number of hours that employees must work. Your Group is required to inform Subscribers of its eligibility requirements.

Service Area eligibility requirements

The "Definitions" section describes our Service Area and how it may change.

Subscribers must live or work inside our Service Area at the time they enroll. If after enrollment the Subscriber no longer lives or works inside our Service Area, the Subscriber can continue membership unless (1) they live inside or move to the service area of another Region and do not work inside our Service Area, or (2) your Group does not allow continued enrollment of Subscribers who do not live or work inside our Service Area.

Dependent children of the Subscriber or of the Subscriber's Spouse may live anywhere inside or outside our Service Area. Other Dependents may live anywhere, except that they are not eligible to enroll or to continue enrollment if they live in or move to the service area of another Region.

If you are not eligible to continue enrollment because you live in or move to the service area of another Region, please contact your Group to learn about your Group health care options:

- **Regions outside California**. You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*
- **Southern California Region's service area**. Your Group may have an arrangement with us that permits membership in the Southern California Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*. All terms and conditions in your application for enrollment in the Northern California Region, including the Arbitration Agreement, will continue to apply if the Subscriber does not submit a new enrollment form

For more information about the service areas of the other Regions, please call Member Services.

Eligibility as a Subscriber

You may be eligible to enroll and continue enrollment as a Subscriber if you are:

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service considers you self-employed)

Eligibility as a Dependent

Enrolling a Dependent

Dependent eligibility is subject to your Group's eligibility requirements, which are not described in this *EOC*. You can obtain your Group's eligibility requirements directly from your Group. If you are a Subscriber under this *EOC* and if your Group allows enrollment of Dependents, Health Plan allows the following persons to enroll as your Dependents under this *EOC*:

- Your Spouse
- Your or your Spouse's Dependent children, who meet the requirements described under "Age limit of Dependent children," if they are any of the following:
  - sons, daughters, or stepchildren
  - adopted children
  - children placed with you for adoption
  - foster children if you or your Spouse have the legal authority to direct their care
  - children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Children whose parent is a Dependent child under your family coverage (including adopted children and children placed with your Dependent child for adoption or foster care), if they meet all of the following requirements:
  - they are not married and do not have a domestic partner (for the purposes of this requirement only,

"domestic partner" means someone who is registered and legally recognized as a domestic partner by California)

- ♦ they meet the requirements described under "Age limit of Dependent children"
- ♦ they receive all of their support and maintenance from you or your Spouse
- ♦ they permanently reside with you or your Spouse

If you have a baby

If you have a baby while enrolled under this *EOC*, the baby is not automatically enrolled in this plan. The Subscriber must request enrollment of the baby as described under "Special enrollment" in the "How to Enroll and When Coverage Begins" section below. If the Subscriber does not request enrollment within this special enrollment period, the baby will only be covered under this plan for 31 days (including the date of birth), or until the date the baby is enrolled in other coverage, whichever happens first.

Age limit of Dependent children

Children must be under age 26 as of the effective date of this *EOC* to enroll as a Dependent under your plan.

Dependent children are eligible to remain on the plan through the end of the month in which they reach the age limit.

Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption, but not including children placed with you for foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:

- They meet all requirements to be a Dependent except for the age limit
- Your Group permits enrollment of Dependents
- They are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
- They receive 50 percent or more of their support and maintenance from you or your Spouse
- If requested, you give us proof of their incapacity and dependency within 60 days after receiving our request (see "Disabled Dependent certification" below in this "Eligibility as a Dependent" section)

Disabled Dependent certification

Proof may be required for a Dependent to be eligible to continue coverage as a disabled Dependent. If we request it, the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

- If the child is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as a disabled dependent, we will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as a disabled dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled dependent
- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child's incapacity and dependency as well as proof of the child's coverage under your prior coverage. In the future, you must provide proof of the child's continued incapacity and dependency within 60 days after you receive our request, but not more frequently than annually

If the Subscriber is enrolled under a Kaiser Permanente Medicare plan

The dependent eligibility rules described in the "Eligibility as a Dependent" section also apply if you are a subscriber under a Kaiser Permanente Medicare plan offered by your Group (please ask your Group about your membership options). All of your dependents who are enrolled under this or any other non-Medicare evidence of coverage offered by your Group must be enrolled under the same non-Medicare evidence of coverage. A "non-Medicare" evidence of coverage is one that does not require members to have Medicare.

Persons barred from enrolling

You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

Members with Medicare and retirees

This *EOC* is not intended for most Medicare beneficiaries and some Groups do not offer coverage to retirees. If, during the term of this *EOC*, you are (or become) eligible for Medicare or you retire, please ask your Group about your membership options as follows:

- If a Subscriber who has Medicare Part B retires and the Subscriber's Group has a Kaiser Permanente Senior Advantage plan for retirees, the Subscriber should enroll in the plan if eligible
- If the Subscriber has dependents who have Medicare and your Group has a Kaiser Permanente Senior Advantage plan (or of one our other plans that require members to have Medicare), the Subscriber may be able to enroll them as dependents under that plan
- If the Subscriber retires and your Group does not offer coverage to retirees, you may be eligible to continue membership as described in the "Continuation of Membership" section
- If federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary, your coverage under this *EOC* will be the same as it would be if you had not become eligible for Medicare. However, you may also be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you have Medicare Part B
- If you are (or become) eligible for Medicare and are in a class of beneficiaries for which your Group's health care coverage is secondary to Medicare, you should consider enrollment in Kaiser Permanente Senior Advantage through your Group if you are eligible
- If none of the above applies to you and you are eligible for Medicare or you retire, please ask your Group about your membership options

Note: If you are enrolled in a Medicare plan and lose Medicare eligibility, you may be able to enroll under this *EOC* if permitted by your Group (please ask your Group for details).

When Medicare is primary

Your Group's Premiums may increase if you are (or become) eligible for Medicare Part A or B as primary coverage, and you are not enrolled through your Group in Kaiser Permanente Senior Advantage for any reason (even if you are not eligible to enroll or the plan is not available to you).

When Medicare is secondary

Medicare is the primary coverage except when federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary. Members who have Medicare when Medicare is secondary by law are subject to the same Premiums and receive the same benefits as Members who are under age 65 and do not have Medicare. In addition, any such Member for whom Medicare is secondary by law and who meets the eligibility requirements for the Kaiser Permanente Senior Advantage plan applicable when Medicare is secondary may also enroll in that plan if it is available. These Members receive the benefits and coverage described in this *EOC* and the Kaiser Permanente Senior Advantage evidence of coverage applicable when Medicare is secondary.

Medicare late enrollment penalties

If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B. However, if you delay enrollment in Part B because you or your spouse are still working and have coverage through an employer group health plan, you may not have to pay the penalty. Also, if you are (or become) eligible for Medicare and go without creditable prescription drug coverage (drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage) for a continuous period of 63 days or more, you may have to pay a late enrollment penalty if you later sign up for Medicare prescription drug coverage. If you are (or become) eligible for Medicare, your Group is responsible for informing you about whether your drug coverage under this *EOC* is creditable prescription drug coverage at the times required by the Centers for Medicare & Medicaid Services and upon your request.

How to Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, enrollment is permitted as described below and membership begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that your Group may have additional requirements, which allow enrollment in other situations.

If you are eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a Kaiser Permanente Senior Advantage evidence of coverage offered by your Group, the rules for enrollment of Dependents in this "How to Enroll and When Coverage Begins" section apply, not the rules for enrollment of dependents in the subscriber's evidence of coverage.

New employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application to your Group within 31 days.

Effective date of coverage

The effective date of coverage for new employees and their eligible family Dependents is determined by your Group in accord with waiting period requirements in state and federal law. Your Group is required to inform the Subscriber of the date your membership becomes effective. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Open enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan–approved enrollment application to your Group during your Group's open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage.

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible because you experience a qualifying event (sometimes called a "triggering event") as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber

Special enrollment due to new Dependents

You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, or placement for adoption by submitting to your Group a Health Plan–approved enrollment application.

The effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, date of adoption, or the date you or your Spouse have newly assumed a legal right to control health care in anticipation of adoption.

Special enrollment due to loss of other coverage

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

- The Subscriber or at least one of the Dependents had other coverage when they previously declined all coverage through your Group
- The loss of the other coverage is due to one of the following:
  - ♦ exhaustion of COBRA coverage
  - ♦ termination of employer contributions for non-COBRA coverage
  - ♦ loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, moving out of the plan's service area, reaching the age limit for dependent children, or the subscriber's death, termination of employment, or reduction in hours of employment
  - ♦ loss of eligibility (but not termination for cause) for coverage through Covered California, Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage, or Medi-Cal Access Program coverage
  - ♦ reaching a lifetime maximum on all benefits

Note: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for coverage through Covered California, Medicaid, Children's Health Insurance Program, or Medi-Cal Access Program coverage. The effective date of an

enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special enrollment due to court or administrative order
Within 30 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application.

The effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance
You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

Special enrollment due to reemployment after military service
If you terminated your health care coverage because you were called to active duty in the military service, you may be able to reenroll in your Group's health plan if required by state or federal law. Please ask your Group for more information.

Other special enrollment events
You may enroll as a Subscriber (along with any eligible Dependents) if you or your Dependents were not previously enrolled, and existing Subscribers may add eligible Dependents not previously enrolled, if any of the following are true:

- You lose employment for a reason other than gross misconduct
- Your employment hours are reduced
- You are a Dependent of someone who becomes entitled to Medicare
- You become divorced or legally separated
- You are a Dependent of someone who dies
- A Health Benefit Exchange (such as Covered California) determines that one of the following occurred because of misconduct on the part of a non-Exchange entity that provided enrollment assistance or conducted enrollment activities:
  - a qualified individual was not enrolled in a qualified health plan
  - a qualified individual was not enrolled in the qualified health plan that the individual selected
  - a qualified individual is eligible for, but is not receiving, advance payments of the premium tax credit or cost share reductions

To request special enrollment, you must submit a Health Plan-approved enrollment application to your Group within 30 days after loss of other coverage. You may be required to provide documentation that you have experienced a qualifying event. Membership becomes effective either on the first day of the next month (for applications that are received by the fifteenth day of a month) or on the first day of the month following the next month (for applications that are received after the fifteenth day of a month).

Note: If you are enrolling as a Subscriber along with at least one eligible Dependent, only one of you must meet one of the requirements stated above.

How to Obtain Services

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits" section

- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in this "How to Obtain Services" section

Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*.

Routine Care

If you need the following Services, you should schedule an appointment:

- Preventive Services
- Periodic follow-up care (regularly scheduled follow-up care, such as visits to monitor a chronic condition)
- Other care that is not Urgent Care

To request a non-urgent appointment, you can call your local Plan Facility or request the appointment online. For appointment phone numbers, refer to our Provider Directory or call Member Services. To request an appointment online, go to our website at **kp.org**.

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services.

For information about Out-of-Area Urgent Care, refer to "Urgent Care" in the "Emergency Services and Urgent Care" section.

Not Sure What Kind of Care You Need?

Sometimes it's difficult to know what kind of care you need, so we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week. Here are some of the ways they can help you:

- They can answer questions about a health concern, and instruct you on self-care at home if appropriate
- They can advise you about whether you should get medical care, and how and where to get care (for example, if you are not sure whether your condition is an Emergency Medical Condition, they can help you decide whether you need Emergency Services or Urgent Care, and how and where to get that care)
- They can tell you what to do if you need care and a Plan Medical Office is closed or you are outside our Service Area

You can reach one of these licensed health care professionals by calling the appointment or advice phone number (for phone numbers, refer to our Provider Directory or call Member Services). When you call, a trained support person may ask you questions to help determine how to direct your call.

Your Personal Plan Physician

Personal Plan Physicians provide primary care and play an important role in coordinating care, including hospital stays and referrals to specialists.

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for routine preventive visits listed under "Preventive Services" in the "Benefits" section.

To learn how to select or change to a different personal Plan Physician, visit our website at **kp.org** or call Member Services. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services. You can change your personal Plan Physician at any time for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and physical, occupational, and speech therapies. Also, a Plan Physician must refer you before you can get care from Qualified Autism Service Providers covered under "Behavioral Health Treatment for Autism Spectrum Disorder" in the "Benefits" section. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- The provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the specialist is prescribed. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

The following are examples of Services that require prior authorization by the Medical Group for the Services to be covered ("prior authorization" means that the Medical Group must approve the Services in advance):

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management ("UM") is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at **kp.org/UM** or call Member Services to request a printed copy.

Refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Additional information about prior authorization for durable medical equipment and ostomy and urological supplies

The prior authorization process for durable medical equipment and ostomy and urological supplies includes the use of formulary guidelines. These guidelines were developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology and clinical practice.

If your Plan Physician prescribes one of these items, they will submit a written referral in accord with the UM process described in this "Medical Group authorization procedure for certain referrals" section. If the formulary guidelines do not specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to the Medical Group's designee Plan Physician, who will make an authorization decision as described under "Medical Group's decision time frames" in this "Medical Group authorization procedure for certain referrals" section.

Medical Group's decision time frames

The applicable Medical Group designee will make the authorization decision within the time frame appropriate for your condition, but no later than five business days

after receiving all of the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent Services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If the Medical Group needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your treating physician will be informed about the additional information, testing, or specialist that is needed, and the date that the Medical Group expects to make a decision.

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Travel and lodging for certain referrals

The following are examples of when we will arrange or provide reimbursement for certain travel and lodging expenses in accord with our Travel and Lodging Program Description:

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside our Service Area for certain specialty Services such as a transplant or transgender surgery

For the complete list of specialty Services for which we will arrange or provide reimbursement for travel and lodging expenses, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, refer to the Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Completion of Services from Non–Plan Providers

New Member

If you are currently receiving Services from a Non–Plan Provider in one of the cases listed below under "Eligibility" and your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective, you may be eligible for limited coverage of that Non–Plan Provider's Services.

Terminated provider

If you are currently receiving covered Services in one of the cases listed below under "Eligibility" from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's Services.

Eligibility

The cases that are subject to this completion of Services provision are:

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends
- Serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Mental health conditions in pregnant Members that occur, or can impact the Member, during pregnancy

or during the postpartum period including, but not limited to, postpartum depression. We may cover completion of these Services for up to 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later

- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child's effective date of coverage if the child is a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your effective date of coverage if you are a new Member or within 180 days of the termination date of the terminated provider

To qualify for this completion of Services coverage, all of the following requirements must be met:

- Your Health Plan coverage is in effect on the date you receive the Services
- For new Members, your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective
- You are receiving Services in one of the cases listed above from a Non–Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider's termination date
- For new Members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the Services of your current Non–Plan Provider
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside our Service Area (the requirement that the provider agree to providing Services inside our Service Area doesn't apply if you were receiving covered Services from the provider outside the Service Area when the provider's contract terminated)
- The Services to be provided to you would be covered Services under this *EOC* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from your effective date of coverage if you are a new Member or from the termination date of the Plan Provider

For completion of Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

More information

For more information about this provision, or to request the Services or a copy of our "Completion of Covered Services" policy, please call Member Services.

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non–Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within their scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

Here are some examples of when a second opinion may be provided or authorized:

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial and of your right to file a

grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Contracts with Plan Providers

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital Services for Members, please visit our website at **kp.org** or call Member Services.

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may have to pay the full price of noncovered Services you obtain from Plan Providers or Non–Plan Providers.

When you are referred to a Plan Provider for covered Services, you pay the Cost Share required for Services from that provider as described in this *EOC*.

Termination of a Plan Provider's contract

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for the covered Services you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. You may be eligible to receive Services from a terminated provider; refer to "Completion of Services from Non–Plan Providers" under "Getting a Referral" in this "How to Obtain Services" section.

Provider groups and hospitals

If you are assigned to a provider group or hospital whose contract with us terminates, or if you live within 15 miles of a hospital whose contract with us terminates, we will give you written notice at least 60 days before the termination (or as soon as reasonably possible).

Receiving Care Outside of Your Home Region Service Area

For information about your coverage when you are away from home, visit our website at **kp.org/travel**. You can also call the Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (except closed holidays).

Receiving care in another Kaiser Permanente service area

If you are visiting in another Kaiser Permanente service area, you may receive certain covered Services from designated providers in that other Kaiser Permanente service area, subject to exclusions, limitations, prior authorization or approval requirements, and reductions. For more information about receiving covered Services in another Kaiser Permanente service area, including provider and facility locations, please visit **kp.org/travel** or call our Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (except closed holidays).

For covered Services you receive in another Kaiser Permanente service area, you pay the Cost Share required for Services provided by a Plan Provider inside our Service Area as described in this *EOC*.

Receiving care outside of any Kaiser Permanente service area

If you are traveling outside of any Kaiser Permanente service area, we cover Emergency Services and Urgent Care as described in the "Emergency Services and Urgent Care" section.

Your ID Card

Each Member's Kaiser Permanente ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. When you get care, please bring your ID card and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call Member Services if we ever inadvertently issue you more than one medical record number or if you need to replace your ID card.

Your ID card is for identification only. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services they receive. If you let someone else use your ID card, we may keep your ID card and terminate your membership as described under "Termination for Cause" in the "Termination of Membership" section.

Timely Access to Care

Standards for appointment availability

The California Department of Managed Health Care ("DMHC") developed the following standards for appointment availability. This information can help you know what to expect when you request an appointment.

- Urgent care appointment: within 48 hours
- Routine (non-urgent) primary care appointment (including adult/internal medicine, pediatrics, and family medicine): within 10 business days
- Routine (non-urgent) specialty care appointment with a physician: within 15 business days
- Routine (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician: within 10 business days
- Follow-up (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician, for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition: within 10 business days

If you prefer to wait for a later appointment that will better fit your schedule or to see the Plan Provider of your choice, we will respect your preference. In some cases, your wait may be longer than the time listed if a licensed health care professional decides that a later appointment won't have a negative effect on your health.

The standards for appointment availability do not apply to Preventive Services. Your Plan Provider may recommend a specific schedule for Preventive Services, depending on your needs. Except as specified above for mental health care and substance use disorder treatment, the standards also do not apply to periodic follow-up care for ongoing conditions or standing referrals to specialists.

Timely access to telephone assistance

DMHC developed the following standards for answering telephone questions:

- For telephone advice about whether you need to get care and where to get care: within 30 minutes, 24 hours a day, seven days a week
- For general questions: within 10 minutes during normal business hours

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call Member Services.

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Member Services

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move
- How to replace your Kaiser Permanente ID card

You can reach Member Services in the following ways:

Call	**1-800-464-4000 (**English and more than 150 languages using interpreter services**)** **1-800-788-0616 (**Spanish**)** **1-800-757-7585 (**Chinese dialects**)** TTY users call **711** 24 hours a day, seven days a week (except closed holidays)
Visit	Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
Write	Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
Website	**kp.org**

Cost Share estimates

For information about estimates, see "Getting an estimate of your Cost Share" under "Your Cost Share" in the "Benefits" section.

Plan Facilities

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory for your Home Region. The directory describes the types of covered Services that are available from each Plan Facility, because some facilities provide

only specific types of covered Services. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital emergency departments (for emergency department locations, refer to our Provider Directory or call Member Services)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call Member Services)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services office (for locations, refer to our Provider Directory or call Member Services)

Note: State law requires evidence of coverage documents to include the following notice:

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Kaiser Permanente Member Services, to ensure that you can obtain the health care services that you need.

Please be aware that if a Service is covered but not available at a particular Plan Facility, we will make it available to you at another facility.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world.

Emergency Services are available from Plan Hospital emergency departments 24 hours a day, seven days a week.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the emergency department) after your treating physician determines that this condition is Stabilized. Post-Stabilization Care also includes durable medical equipment covered under this *EOC*, if it is Medically Necessary after discharge from a hospital, and related to the same Emergency Medical Condition. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section. We cover Post-Stabilization Care from a Non–Plan Provider only if we provide prior authorization for the care or if otherwise required by applicable law ("prior authorization" means that we must approve the Services in advance).

To request prior authorization, the Non–Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non–Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover Post-Stabilization Care or related transportation provided by Non–Plan Providers that has not been authorized. If you receive care from a

Non–Plan Provider that we have not authorized, you may have to pay the full cost of that care. If you are admitted to a Non–Plan Hospital, please notify us as soon as possible by calling **1-800-225-8883** or the notification phone number on your ID card.

Your Cost Share

Your Cost Share for covered Emergency Services and Post-Stabilization Care is described in the "Cost Share Summary" section of this *EOC*. Your Cost Share is the same whether you receive the Services from a Plan Provider or a Non–Plan Provider. For example:

- If you receive Emergency Services in the emergency department of a Non–Plan Hospital, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non–Plan Hospital, you pay the Cost Share for hospital inpatient Services as described in the "Cost Share Summary" under "Hospital inpatient Services"
- If we gave prior authorization for durable medical equipment after discharge from a Non–Plan Hospital, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"

Urgent Care

Inside our Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call Member Services.

Out-of-Area Urgent Care

If you need Urgent Care due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), we cover Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health from a Non–Plan Provider if all of the following are true:

- You receive the Services from Non–Plan Providers while you are temporarily outside our Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers if the Services would have been covered under this *EOC* if you had received them from Plan Providers.

To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services. We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care, except for durable medical equipment covered under this *EOC*. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section. If you require durable medical equipment related to your Urgent Care after receiving Out-of-Area Urgent Care, your provider must obtain prior authorization as described under "Getting a Referral" in the "How to Obtain Services" section.

Your Cost Share

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in the "Cost Share Summary" section of this *EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non–Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment Services," in addition to the Cost Share for the Urgent Care evaluation
- If we gave prior authorization for durable medical equipment provided as part of Out-of-Area Urgent Care, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"

Note: If you receive Urgent Care in an emergency department, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care."

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits" section, you are not responsible for any amounts beyond your Cost Share for covered Emergency Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. Also, you may be required to pay and file a claim for any Services prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Benefits

This section describes the Services that are covered under this *EOC*.

Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by state or federal law. Services are subject to exclusions and limitations described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. Except as otherwise described in this *EOC*, all of the following conditions must be satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - Preventive Services
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits" section
  - other health care items and services
- The Services are provided, prescribed, authorized, or directed by a Plan Physician, except for:
  - drugs prescribed by dentists, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" below
  - emergency ambulance Services, as described under "Ambulance Services" below
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - Covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
- You receive the Services from Plan Providers inside our Service Area, except for:
  - authorized referrals, as described under "Getting a Referral" in the "How to Obtain Services" section
  - emergency ambulance Services, as described under "Ambulance Services" below
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - hospice care, as described under "Hospice Care" below
  - Covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
- The Medical Group has given prior authorization for the Services, if required, as described under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

Please also refer to:

- The "Emergency Services and Urgent Care" section for information about how to obtain covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care
- Our Provider Directory for the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance.

If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your

Cost Share for those Services will be Charges until you reach the Drug Deductible.

Refer to the "Cost Share Summary" section of this *EOC* for the amount you will pay for Services.

General rules, examples, and exceptions

Your Cost Share for covered Services will be the Cost Share in effect on the date you receive the Services, except as follows:

- If you are receiving covered hospital inpatient or Skilled Nursing Facility Services on the effective date of this *EOC*, you pay the Cost Share in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Share in effect on the date you receive the Services
- For items ordered in advance, you pay the Cost Share in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Share when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription

Cost Share for Services received by newborn children of a Member

During the 31 days of automatic coverage for newborn children described under "If you have a baby" under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, the parent or guardian of the newborn must pay the Cost Share indicated in the "Cost Share Summary" section of this *EOC* for any Services that the newborn receives, whether or not the newborn is enrolled. When the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, the Cost Share for those Services will be Charges if the newborn has not met the Plan Deductible.

Payment toward your Cost Share (and when you may be billed)

In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as a routine physical maintenance exam and laboratory tests), you may be required to pay separate Cost Share for each of those Services. Keep in mind that your payment toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay (or you may be billed for) Cost Share amounts in addition to the amount you pay at check-in:

- You receive non-preventive Services during a preventive visit. For example, you go in for a routine physical maintenance exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional non-preventive diagnostic Services
- You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional diagnostic Services
- You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay (or you will be billed for) your Cost Share for these additional treatment Services
- You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be billed for) your Cost Share for the consultation with the specialist

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share (for example, some Laboratory Departments are not able to collect Cost Share, or your Plan Provider is not able to collect Cost Share, if any, for Telehealth Visits you receive at home).

When we send you a bill, it will list Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. Your current bill may not always reflect your most recent

Charges and payments. Any Charges and payments that are not on the current bill will appear on a future bill. Sometimes, you may see a payment but not the related Charges for Services. That could be because your payment was recorded before the Charges for the Services were processed. If so, the Charges will appear on a future bill. Also, you may receive more than one bill for a single outpatient visit or inpatient stay. For example, you may receive a bill for physician services and a separate bill for hospital services. If you don't see all the Charges for Services on one bill, they will appear on a future bill. If we determine that you overpaid and are due a refund, then we will send a refund to you within four weeks after we make that determination. If you have questions about a bill, please call the phone number on the bill.

In some cases, a Non–Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits

The Cost Share for a Primary Care Visit applies to evaluations and treatment provided by generalists in internal medicine, pediatrics, or family practice, and by specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Some physician specialists provide primary care in addition to specialty care but are not designated as Primary Care Physicians. If you receive Services from one of these specialists, the Cost Share for a Physician Specialist Visit will apply to all consultations, evaluations, and treatment provided by the specialist except for routine preventive counseling and exams listed under "Preventive Services" in this "Benefits" section. For example, if your personal Plan Physician is a specialist in internal medicine or obstetrics/gynecology who is not a Primary Care Physician, you will pay the Cost Share for a Physician Specialist Visit for all consultations, evaluations, and treatment by the specialist except routine preventive counseling and exams listed under "Preventive Services" in this "Benefits" section. The Non-Physician Specialist Visit Cost Share applies to consultations, evaluations, and treatment provided by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Noncovered Services

If you receive Services that are not covered under this *EOC*, you may have to pay the full price of those Services. Payments you make for noncovered Services do not apply to any deductible or out-of-pocket maximum.

Benefit limits

Some benefits may include a limit on the number of visits, days, or dollar amount that will be covered under your plan during a specified time period. If a benefit includes a limit, this will be indicated in the "Cost Share Summary" section of this *EOC*. The time period associated with a benefit limit may not be the same as the term of this *EOC*. We will count all Services you receive during the benefit limit period toward the benefit limit, including Services you received under a prior Health Plan *EOC* (as long as you have continuous coverage with Health Plan). Note: We will not count Services you received under a prior Health Plan *EOC* when you first enroll in individual plan coverage or a new employer group's plan, when you move from group to individual plan coverage (or vice versa), or when you received Services under a Kaiser Permanente Senior Advantage evidence of coverage. If you are enrolled in the Kaiser Permanente POS Plan, refer to your KPIC *Certificate of Insurance* and *Schedule of Coverage* for benefit limits that apply to your separate indemnity coverage provided by the Kaiser Permanente Insurance Company ("KPIC").

Getting an estimate of your Cost Share

If you have questions about the Cost Share for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at **kp.org/memberestimates** to use our cost estimate tool or call Member Services.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday 6 a.m. to 5 p.m. Refer to the "Cost Share Summary" section of this *EOC* to find out if you have a Plan Deductible
- For all other Cost Share estimates, please call **1-800-464-4000** (TTY users call **711**) 24 hours a day, seven days a week (except closed holidays)

Cost Share estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services. Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Drug Deductible

This *EOC* does not include a Drug Deductible.

Plan Deductible

This *EOC* does not include a Plan Deductible.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *EOC*.

Note: If Charges for Services are less than the Copayment described in this *EOC*, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum.

Plan Out-of-Pocket Maximum

There is a limit to the total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for covered Services that you receive in the same Accumulation Period. The Services that apply to the Plan Out-of-Pocket Maximum are described under the "Payments that count toward the Plan Out-of-Pocket Maximum" section below. Refer to the "Cost Share Summary" section of this *EOC* for your applicable Plan Out-of-Pocket Maximum amounts.

If you are a Member in a Family of two or more Members, you reach the Plan Out-of-Pocket Maximum either when you reach the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the Plan Out-of-Pocket Maximum for any one Member. For Services subject to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Cost Share during the remainder of the Accumulation Period until either they reach the maximum for any one Member or your Family reaches the Family maximum.

Payments that count toward the Plan Out-of-Pocket Maximum

Any payments you make toward the Plan Deductible or Drug Deductible, if applicable, apply toward the maximum.

Most Copayments and Coinsurance you pay for covered Services apply to the maximum, however some may not. To find out whether a Copayment or Coinsurance for a covered Service will apply to the maximum refer to the "Cost Share Summary" section of this *EOC*.

If your plan includes pediatric dental Services described in a Pediatric Dental Services Amendment to this *EOC*, those Services will apply toward the maximum. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC's* Table of Contents.

Accrual toward deductibles and out-of-pocket maximums

To see how close you are to reaching your deductibles, if any, and out-of-pocket maximums, use our online Out-of-Pocket Summary tool at **kp.org/outofpocket** or call Member Services. We will provide you with accrual balance information for every month that you receive Services until you reach your individual out-of-pocket maximums or your Family reaches the Family out-of-pocket maximums.

We will provide accrual balance information by mail unless you have opted to receive notices electronically. You can change your document delivery preferences at any time at **kp.org** or by calling Member Services.

Administered Drugs and Products

Administered drugs and products are medications and products that require administration or observation by medical personnel, such as:

- Whole blood, red blood cells, plasma, and platelets
- Allergy antigens (including administration)
- Cancer chemotherapy drugs and adjuncts
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood
- Other administered drugs and products

We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

Certain administered drugs are Preventive Services. Refer to "Reproductive Health Services" for information about administered contraceptives and refer to "Preventive Services" for information on immunizations.

Ambulance Services

Emergency

We cover Services of a licensed ambulance anywhere in the world without prior authorization (including

transportation through the 911 emergency response system where available) in the following situations:

- You reasonably believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered emergency ambulance Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance and psychiatric transport van Services if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

Ambulance Services exclusions

- Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a Plan Provider

Bariatric Surgery

We cover hospital inpatient Services related to bariatric surgical procedures (including room and board, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
- A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

For covered Services related to bariatric surgical procedures that you receive, you will pay the Cost Share you would pay if the Services were not related to a bariatric surgical procedure. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

For the following Services, refer to these sections

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")

Behavioral Health Treatment for Autism Spectrum Disorder

The following terms have special meaning when capitalized and used in this "Behavioral Health Treatment for Autism Spectrum Disorder" section:

- "Qualified Autism Service Provider" means a provider who has the experience and competence to design, supervise, provide, or administer treatment for autism spectrum disorder and is either of the following:
  - a person who is certified by a national entity (such as the Behavior Analyst Certification Board) with a certification that is accredited by the National Commission for Certifying Agencies
  - a person licensed in California as a physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist
- "Qualified Autism Service Professional" means an individual who meets all of the following criteria:
  - provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider
  - is supervised by a Qualified Autism Service Provider
  - provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
  - is a behavioral health treatment provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior

Management Assistant, Behavior Management Consultant, or Behavior Management Program

- ♦ has training and experience in providing Services for autism spectrum disorder pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code
- ♦ is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan

- "Qualified Autism Service Paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:
  - ♦ is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice
  - ♦ provides treatment and implements Services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
  - ♦ meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations
  - ♦ has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers
  - ♦ is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan

We cover behavioral health treatment for autism spectrum disorder (including applied behavior analysis and evidence-based behavior intervention programs) that develops or restores, to the maximum extent practicable, the functioning of a person with autism spectrum disorder and that meets all of the following criteria:

- The Services are provided inside our Service Area
- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is provided under a treatment plan prescribed by a Plan Provider who is a Qualified Autism Service Provider
- The treatment is administered by a Plan Provider who is one of the following:
  - ♦ a Qualified Autism Service Provider
  - ♦ a Qualified Autism Service Professional supervised by the Qualified Autism Service Provider
  - ♦ a Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the Member being treated
- The treatment plan is reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate
- The treatment plan requires the Qualified Autism Service Provider to do all of the following:
  - ♦ describe the Member's behavioral health impairments to be treated
  - ♦ design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported
  - ♦ provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating autism spectrum disorder
  - ♦ discontinue intensive behavioral intervention Services when the treatment goals and objectives are achieved or no longer appropriate
- The treatment plan is not used for either of the following:
  - ♦ for purposes of providing (or for the reimbursement of) respite care, day care, or educational services
  - ♦ to reimburse a parent for participating in the treatment program

We also cover behavioral health treatment that meets the same criteria to treat mental health conditions other than autism spectrum disorder when behavioral health treatment is clinically indicated.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section). For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Behavioral health treatment for autism spectrum disorder provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Services to diagnose autism spectrum disorder and Services to develop and revise the treatment plan (refer to "Mental Health Services")

Dental and Orthodontic Services

We do not cover most dental and orthodontic Services under this *EOC*, but we do cover some dental and orthodontic Services as described in this "Dental and Orthodontic Services" section.

For covered dental and orthodontic procedures that you may receive, you will pay the Cost Share you would pay if the Services were not related to dental and orthodontic Services. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

Dental Services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental Services for transplants

We cover dental services that are Medically Necessary to free the mouth from infection in order to prepare for a transplant covered under "Transplant Services" in this "Benefits" section, if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

For dental procedures at a Plan Facility, we provide general anesthesia and the facility's Services associated with the anesthesia if all of the following are true:

- You are under age 7, or you are developmentally disabled, or your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

We do not cover any other Services related to the dental procedure, such as the dentist's Services.

Dental and orthodontic Services for cleft palate

We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic Services, if they meet all of the following requirements:

- The Services are an integral part of a reconstructive surgery for cleft palate that we are covering under "Reconstructive Surgery" in this "Benefits" section ("cleft palate" includes cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate)
- A Plan Provider provides the Services or the Medical Group authorizes a referral to a Non–Plan Provider who is a dentist or orthodontist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)

For the following Services, refer to these sections

- Accidental injury to teeth (refer to "Injury to Teeth")
- Office visits not described in the "Dental and Orthodontic Services" section (refer to "Office Visits")
- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis Care

We cover acute and chronic dialysis Services if all of the following requirements are met:

- The Services are provided inside our Service Area
- You satisfy all medical criteria developed by the Medical Group and by the facility providing the dialysis
- A Plan Physician provides a written referral for care at the facility

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our Service Area. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

For the following Services, refer to these sections

- Durable medical equipment for home use (refer to "Durable Medical Equipment ("DME") for Home Use")
- Hospital inpatient Services (refer to "Hospital Inpatient Services")
- Office visits not described in the "Dialysis Care" section (refer to "Office Visits")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis care exclusions

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment ("DME") for Home Use

DME coverage rules

DME for home use is an item that meets the following criteria:

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to an individual with an illness or injury
- The item is appropriate for use in the home

For a DME item to be covered, all of the following requirements must be met:

- Your *EOC* includes coverage for the requested DME item
- A Plan Physician has prescribed the DME item for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

Base DME Items

We cover Base DME Items (including repair or replacement of covered equipment) if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met. "Base DME Items" means the following items:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress

- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Peak flow meters
- Phototherapy blankets for treatment of jaundice in newborns

Supplemental DME items

We cover DME that is not described under "Base DME Items" or "Breastfeeding supplies," including repair and replacement of covered equipment, if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met.

Breastfeeding supplies

We cover one retail-grade breast pump per pregnancy and associated supplies, as listed on our website at **kp.org/prevention**. We will decide whether to rent or purchase the item and we choose the vendor. We cover this pump for convenience purposes. The pump is not subject to prior authorization requirements.

If you or your baby has a medical condition that requires the use of a breast pump, we cover a hospital-grade breast pump and the necessary supplies to operate it, in accord with the coverage rules described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section.

Outside our Service Area

We do not cover most DME for home use outside our Service Area. However, if you live outside our Service Area, we cover the following DME (subject to the Cost Share and all other coverage requirements that apply to DME for home use inside our Service Area) when the item is dispensed at a Plan Facility:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Canes (standard curved handle)
- Crutches (standard)
- Insulin pumps and supplies to operate the pump, after completion of training and education on the use of the pump
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

For the following Services, refer to these sections

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Durable medical equipment related to an Emergency Medical Condition or Urgent Care episode (refer to "Post-Stabilization Care" and "Out-of-Area Urgent Care")
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Insulin and any other drugs administered with an infusion pump (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

DME for home use exclusions

- Comfort, convenience, or luxury equipment or features except for retail-grade breast pumps as described under "Breastfeeding supplies" in this "Durable Medical Equipment ("DME") for Home Use" section
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss, theft, or misuse

Emergency Services and Urgent Care

We cover the following Services:

- Emergency department visits
- Urgent Care consultations, evaluations, and treatment

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")

Fertility Services

"Fertility Services" means treatments and procedures to help you become pregnant.

Before starting or continuing a course of fertility Services, you may be required to pay initial and subsequent deposits toward your Cost Share for some or all of the entire course of Services, along with any past-due fertility-related Cost Share. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Cost Share for the procedure, along with any past-due fertility-related Cost Share, before you can schedule a fertility procedure.

Diagnosis and treatment of infertility

For purposes of this "Diagnosis and treatment of infertility" section, "infertility" means not being able to get pregnant or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or having a medical or other demonstrated condition that is recognized by a Plan Physician as a cause of infertility.

We cover the following Services for the diagnosis and treatment of infertility:

- Office visits
- Outpatient surgery and outpatient procedures
- Outpatient imaging and laboratory Services
- Outpatient administered drugs that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility
- Hospital inpatient stay directly related to diagnosis and treatment of infertility

Artificial insemination

We cover the following Services for artificial insemination:

- Office visits
- Outpatient surgery and outpatient procedures
- Outpatient imaging and laboratory Services
- Outpatient administered drugs that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility
- Hospital inpatient stays directly related to diagnosis and treatment of infertility

Assisted reproductive technology ("ART") Services

ART Services such as in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), or zygote intrafallopian transfer ("ZIFT") are not covered under this *EOC*.

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Diagnostic Services provided by Plan Providers who are not physicians, such as EKGs and EEGs (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Fertility Services exclusions

- Services to reverse voluntary, surgically induced infertility
- Semen and eggs (and Services related to their procurement and storage)
- ART Services, such as ovum transplants, GIFT, IVF, and ZIFT

Fertility Preservation Services for Iatrogenic Infertility

Standard fertility preservation Services are covered for Members undergoing treatment or receiving covered Services that may directly or indirectly cause iatrogenic infertility. Fertility preservation Services do not include diagnosis or treatment of infertility.

For covered fertility preservation Services that you receive, you will pay the Cost Share you would pay if the Services were not related to fertility preservation. For example, see "Outpatient surgery and outpatient procedures" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for outpatient procedures.

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this *EOC*.

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). Kaiser Permanente also offers health education counseling, programs, and materials that are not covered, and you may be required to pay a fee.

For more information about our health education counseling, programs, and materials, please contact a Health Education Department or Member Services or go to our website at **kp.org**.

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction
- Physician Specialist Visits to diagnose and treat hearing problems

Hearing aids

Hearing aids and related Services are not covered under this *EOC*. For internally implanted devices, see "Prosthetic and Orthotic Devices" in this "Benefits" section.

For the following Services, refer to these sections

- Routine hearing screenings when performed as part of a routine physical maintenance exam (refer to "Preventive Services")
- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection or outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists.

We cover home health care only if all of the following are true:

- You are substantially confined to your home (or a friend's or relative's home)
- Your condition requires the Services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home
- The Services are provided inside our Service Area

We cover only part-time or intermittent home health care, as follows:

- Up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health aide
- Up to three visits per day (counting all home health visits)
- Up to 100 visits per Accumulation Period (counting all home health visits)

Note: If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours, that counts as two visits.

For the following Services, refer to these sections

- Behavioral health treatment for autism spectrum disorder (refer to "Behavioral Health Treatment for Autism Spectrum Disorder")

- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusions

- Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or a Skilled Nursing Facility
- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

We cover the hospice Services listed below only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area (including a friend's or relative's home even if you live there temporarily)
- The Services are provided by a licensed hospice agency that is a Plan Provider
- A Plan Physician determines that the Services are necessary for the palliation and management of your terminal illness and related conditions

If all of the above requirements are met, we cover the following hospice Services, if necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, and speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (your Plan Pharmacy can tell you if a drug you take is one of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient Services limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling

We also cover the following hospice Services only during periods of crisis when they are Medically Necessary to achieve palliation or management of acute medical symptoms:

- Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
- Short-term inpatient Services required at a level that cannot be provided at home

Hospital Inpatient Services

We cover the following inpatient Services in a Plan Hospital, when the Services are generally and

customarily provided by acute care general hospitals inside our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment Services, including MRI, CT, and PET scans
- Whole blood, red blood cells, plasma, platelets, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, refer to "Office Visits" in this "Benefits" section)
- Behavioral health treatment that is Medically Necessary to treat mental health conditions that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that are listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*
- Respiratory therapy
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program)
- Medical social services and discharge planning

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")
- Bariatric surgical procedures (refer to "Bariatric Surgery")
- Dental and orthodontic procedures (refer to "Dental and Orthodontic Services")
- Dialysis care (refer to "Dialysis Care")
- Fertility preservation Services for iatrogenic infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Services related to diagnosis and treatment of infertility, artificial insemination, or assisted reproductive technology (refer to "Fertility Services")
- Hospice care (refer to "Hospice Care")
- Mental health Services (refer to "Mental Health Services")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Reconstructive surgery Services (refer to "Reconstructive Surgery")
- Services in connection with a clinical trial (refer to "Services in Connection with a Clinical Trial")
- Skilled inpatient Services in a Plan Skilled Nursing Facility (refer to "Skilled Nursing Facility Care")
- Substance use disorder treatment Services (refer to "Substance Use Disorder Treatment")
- Transplant Services (refer to "Transplant Services")

Injury to Teeth

Services for accidental injury to teeth are not covered under this *EOC*.

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the prevention, diagnosis, or treatment of Mental Health Conditions. A "Mental Health Condition" is a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.*

Outpatient mental health Services

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed

health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Health Condition
- Outpatient Services for the purpose of monitoring drug therapy

Intensive psychiatric treatment programs

We cover intensive psychiatric treatment programs at a Plan Facility, such as:

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient program
- Psychiatric observation for an acute psychiatric crisis

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized mental health treatment, the Services are generally and customarily provided by a mental health residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Discharge planning

Inpatient psychiatric hospitalization

We cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section). For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Telehealth Visits (refer to "Telehealth Visits")

Office Visits

We cover the following:

- Primary Care Visits and Non-Physician Specialist Visits
- Physician Specialist Visits
- Group appointments
- Acupuncture Services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain)
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")

Ostomy and Urological Supplies

We cover ostomy and urological supplies if the following requirements are met:

- A Plan Physician has prescribed ostomy and urological supplies for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in

"Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section

- The Services are provided inside our Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor.

Ostomy and urological supplies exclusions

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

We cover the following Services only when part of care covered under other headings in this "Benefits" section. The Services must be prescribed by a Plan Provider.

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans
- Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds
- Nuclear medicine
- Routine retinal photography screenings
- Laboratory tests, including tests to monitor the effectiveness of dialysis and tests for specific genetic disorders for which genetic counseling is available
- Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs)
- Radiation therapy
- Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section and (2) the equipment is provided inside our Service Area. (Coverage for ultraviolet light therapy equipment is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.)

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")
- Outpatient imaging and laboratory Services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to "Preventive Services")
- Outpatient procedures that include imaging and diagnostic Services (refer to "Outpatient Surgery and Outpatient Procedures")
- Services related to diagnosis and treatment of infertility, artificial insemination, or assisted reproductive technology ("ART") Services (refer to "Fertility Services")

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services exclusions

- Ultraviolet light therapy comfort, convenience, or luxury equipment or features
- Repair or replacement of ultraviolet light therapy equipment due to loss, theft, or misuse

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, in accord with our drug formulary guidelines, subject to any applicable exclusions or limitations under this *EOC*. We cover items described in this section when prescribed as follows:

- Items prescribed by Plan Providers, within the scope of their licensure and practice
- Items prescribed by the following Non–Plan Providers:
  - Dentists if the drug is for dental care
  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges

for the item and file a claim for reimbursement as described under "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)

How to obtain covered items

You must obtain covered items at a Plan Pharmacy or through our mail-order service unless you obtain the item as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section.

For the locations of Plan Pharmacies, refer to our Provider Directory or call Member Services.

Refills

You may be able to order refills at a Plan Pharmacy, through our mail-order service, or through our website at **kp.org/rxrefill**. A Plan Pharmacy can give you more information about obtaining refills, including the options available to you for obtaining refills. For example, a few Plan Pharmacies don't dispense refills and not all drugs can be mailed through our mail-order service. Please check with a Plan Pharmacy if you have a question about whether your prescription can be mailed or obtained at a Plan Pharmacy. Items available through our mail-order service are subject to change at any time without notice.

Day supply limit

The prescribing physician or dentist determines how much of a drug, supply, item, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30- or 100-day supply (or 365-day supply if the item is a hormonal contraceptive) for you. Upon payment of the Cost Share specified in the "Outpatient prescription drugs, supplies, and supplements" section of the "Cost Share Summary," you will receive the supply prescribed up to the day supply limit also specified in this section. The maximum you may receive at one time of a covered item, other than a hormonal contraceptive, is either one 30-day supply in a 30-day period or one 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit.

If your plan includes coverage for hormonal contraceptives, the maximum you may receive at one time of contraceptive drugs is a 365-day supply. Refer to the "Cost Share Summary" section of this *EOC* to find out if your plan includes coverage for hormonal contraceptives.

If your plan includes coverage for sexual dysfunction drugs, the maximum you may receive at one time of episodic drugs prescribed for the treatment of sexual dysfunction disorders is eight doses in any 30-day period or up to 27 doses in any 100-day period. Refer to the "Cost Share Summary" section of this *EOC* to find out if your plan includes coverage for sexual dysfunction drugs.

The pharmacy may reduce the day supply dispensed at the Cost Share specified in the "Outpatient prescription drugs, supplies, and supplements" section of the "Cost Share Summary" to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs).

About the drug formulary

The drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians and pharmacists, selects drugs for the drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature. The drug formulary is updated monthly based on new information or new drugs that become available. To find out which drugs are on the formulary for your plan, please visit our website at **kp.org/formulary**. If you would like to request a copy of the drug formulary for your plan, please call Member Services. Note: The presence of a drug on the drug formulary does not necessarily mean that it will be prescribed for a particular medical condition.

Formulary exception process

Drug formulary guidelines allow you to obtain a non-formulary prescription drug (those not listed on our drug formulary for your condition) if it would otherwise be covered by your plan, as described above, and it is Medically Necessary. If you disagree with a Health Plan determination that a non-formulary prescription drug is not covered, you may file a grievance as described in the "Dispute Resolution" section.

Continuity drugs

If this *EOC* is amended to exclude a drug that we have been covering and providing to you under this *EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the Federal Food and Drug Administration.

About drug tiers

Drugs on the drug formulary are categorized into one of three tiers, as described in the table below. Your Cost Share for covered items may vary based on the tier. Refer to "Outpatient prescription drugs, supplies, and supplements" in the "Cost Share Summary" section of this *EOC* for Cost Share for items covered under this section.

Drug Tier	Description
Generic drugs (Tier 1)	Generic drugs, supplies and supplements, and some low-cost brand-name drugs, supplies, and supplements
Brand drugs (Tier 2)*	Most brand-name drugs, supplies, and supplements
Specialty drugs (Tier 4)	Specialty drugs (see "About specialty drugs")

*Note: This plan does not have a tier for non-formulary drugs ("Tier 3"). You will pay the same Cost Share for non-formulary drugs as you would for formulary drugs, when approved through the formulary exception process described above (the generic drugs, brand drugs, or specialty drugs Cost Share will apply, as applicable).

About specialty drugs

Specialty drugs (Tier 4) are high-cost drugs that are on our specialty drug list. To find out if a drug is on the specialty drugs tier, please visit our website at **kp.org/formulary**. If your Plan Physician prescribes more than a 30-day supply for an outpatient drug, you may be able to obtain more than a 30-day supply at one time, up to the day supply limit for that drug. However, most specialty drugs are limited to a 30-day supply in any 30-day period. Your Plan Pharmacy can tell you if a drug you take is one of these drugs.

General rules about coverage and your Cost Share

We cover the following outpatient drugs, supplies, and supplements as described in this "Outpatient Prescription Drugs, Supplies, and Supplements" section:

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

Note:

- If Charges for the drug, supply, or supplement are less than the Copayment, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum
- Items can change tier at any time, in accord with formulary guidelines, which may impact your Cost Share (for example, if a brand-name drug is added to the specialty drug list, you will pay the Cost Share that applies to drugs on the specialty drugs tier (Tier 4), not the Cost Share for drugs on the brand drugs tier (Tier 2))

Schedule II drugs

You or the prescribing provider can request that the pharmacy dispense less than the prescribed amount of a covered oral, solid dosage form of a Schedule II drug (your Plan Pharmacy can tell you if a drug you take is one of these drugs). Your Cost Share will be prorated based on the amount of the drug that is dispensed. If the pharmacy does not prorate your Cost Share, we will send you a refund for the difference.

Mail-order service

Prescription refills can be mailed within 3 to 5 days at no extra cost for standard U.S. postage. The appropriate Cost Share (according to your drug coverage) will apply and must be charged to a valid credit card.

You may request mail-order service in the following ways:

- To order online, visit **kp.org/rxrefill** (you can register for a secure account at **kp.org/registernow**) or use the KP app from your smartphone or other mobile device
- Call the pharmacy phone number highlighted on your prescription label and select the mail delivery option
- On your next visit to a Kaiser Permanente pharmacy, ask our staff how you can have your prescriptions mailed to you

Note: Restrictions and limitations apply. For example, not all drugs can be mailed and we cannot mail drugs to all states.

Manufacturer coupon program

For outpatient prescription drugs or items that are covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section and obtained at a Plan Pharmacy, you may be able to use approved manufacturer coupons as payment for the Cost Share that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the

coupon does not cover the entire amount of your Cost Share for your prescription. When you use an approved coupon for payment of your Cost Share, the coupon amount and any additional payment that you make will accumulate to your out-of-pocket maximum if applicable. Refer to the "Cost Share Summary" section of this *EOC* to find your applicable out-of-pocket maximum amount and to learn which drugs and items apply to the maximum. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at **kp.org/rxcoupons**.

Base drugs, supplies, and supplements

Cost Share for the following items may be different than other drugs, supplies, and supplements. Refer to "Base drugs, supplies, and supplements" in the "Cost Share Summary" section of this *EOC*:

- Certain drugs for the treatment of life-threatening ventricular arrhythmia
- Drugs for the treatment of tuberculosis
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis
- Hematopoietic agents for dialysis
- Hematopoietic agents for the treatment of anemia in chronic renal insufficiency
- Human growth hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion
- Immunosuppressants and ganciclovir and ganciclovir prodrugs for the treatment of cytomegalovirus when prescribed in connection with a transplant
- Phosphate binders for dialysis patients for the treatment of hyperphosphatemia in end stage renal disease

For the following Services, refer to these sections

- Drugs prescribed for abortion or abortion-related Services (refer to "Reproductive Health Services")
- Administered contraceptives (refer to "Reproductive Health Services")
- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment ("DME") for Home Use")
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment ("DME") for Home Use")
- Outpatient administered drugs that are not contraceptives (refer to "Administered Drugs and Products")

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law
- Drugs prescribed to shorten the duration of the common cold
- Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not apply to:
  - ♦ insulin
  - ♦ over-the-counter drugs covered under "Preventive Services" in this "Benefits" section (this includes tobacco cessation drugs and contraceptive drugs)
  - ♦ an entire class of prescription drugs when one drug within that class becomes available over-the-counter
- All drugs, supplies, and supplements related to assisted reproductive technology ("ART") Services

Outpatient Surgery and Outpatient Procedures

We cover the following outpatient care Services:

- Outpatient surgery
- Outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or in any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Outpatient procedures (including imaging and diagnostic Services) that do not require a licensed staff member to monitor your vital signs (refer to the section that would otherwise apply for the procedure; for example, for radiology procedures that do not require a licensed staff member to monitor your vital signs, refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Preventive Services

We cover a variety of Preventive Services, as listed on our website at **kp.org/prevention**, including the following:

- Services recommended by the United States Preventive Services Task Force with rating of "A" or "B." The complete list of these services can be found at **uspreventiveservicestaskforce.org**
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. The complete list of recommended immunizations can be found at **cdc.gov/vaccines/schedules**
- Preventive services for women recommended by the Health Resources and Services Administration and incorporated into the Affordable Care Act. The complete list of these services can be found at **hrsa.gov/womens-guidelines**

The list of Preventive Services recommended by the above organizations is subject to change. These Preventive Services are subject to all coverage requirements described in this "Benefits" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

If you are enrolled in a grandfathered plan, certain preventive items listed on our website, such as over-the-counter drugs, may not be covered. Refer to the "Certain preventive items" table in the "Cost Share Summary" section of this *EOC* for coverage information. If you have questions about Preventive Services, please call Member Services.

Note: Preventive Services help you stay healthy, before you have symptoms. If you have symptoms, you may need other care, such as diagnostic or treatment Services. If you receive any other covered Services that are not Preventive Services before, during, or after a visit that includes Preventive Services, you will pay the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

For the following Services, refer to these sections

- Breast pumps and breastfeeding supplies (refer to "Breastfeeding supplies" under "Durable Medical Equipment ("DME") for Home Use")
- Health education programs (refer to "Health Education")
- Outpatient drugs, supplies, and supplements that are Preventive Services (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Women's family planning counseling, consultations, and sterilization Services (refer to "Reproductive Health Services")

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

We cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Share that you would pay for obtaining that device.

Base prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic

Devices" section are met, we cover the items described in this "Base prosthetic and orthotic devices" section.

Internally implanted devices
We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this "Benefits" section.

External devices
We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- After Medically Necessary removal of all or part of a breast:
  - ♦ prostheses, including custom-made prostheses when Medically Necessary
  - ♦ up to three brassieres required to hold a prosthesis in any 12-month period
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Enteral pump and supplies
- Tracheostomy tube and supplies
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Supplemental prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the following items:

- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
- Rigid and semi-rigid orthotic devices required to support or correct a defective body part

For the following Services, refer to these sections

- Eyeglasses and contact lenses, including contact lenses to treat aniridia or aphakia (refer to "Vision Services for Adult Members" and "Vision Services for Pediatric Members")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")
- Injectable implants (refer to "Administered Drugs and Products")

Prosthetic and orthotic devices exclusions

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of device due to loss, theft, or misuse
- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications
- Prosthetic and orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)

Reconstructive Surgery

We cover the following reconstructive surgery Services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

For covered Services related to reconstructive surgery that you receive, you will pay the Cost Share you would pay if the Services were not related to reconstructive surgery. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services,

and see "Outpatient surgery and outpatient procedures" in the "Cost Share Summary" for the Cost Share that applies for outpatient surgery.

For the following Services, refer to these sections

- Dental and orthodontic Services that are an integral part of reconstructive surgery for cleft palate (refer to "Dental and Orthodontic Services")
- Office visits not described in the "Reconstructive Surgery" section (refer to "Office Visits")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Telehealth Visits (refer to "Telehealth Visits")

Reconstructive surgery exclusions

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance

Rehabilitative and Habilitative Services

We cover the Services described in this "Rehabilitative and Habilitative Services" section if all of the following requirements are met:

- The Services are to address a health condition
- The Services are to help you keep, learn, or improve skills and functioning for daily living
- You receive the Services at a Plan Facility unless a Plan Physician determines that it is Medically Necessary for you to receive the Services in another location

We cover the following Services:

- Individual outpatient physical, occupational, and speech therapy
- Group outpatient physical, occupational, and speech therapy
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program

For the following Services, refer to these sections

- Behavioral health treatment for autism spectrum disorder (refer to "Behavioral Health Treatment for Autism Spectrum Disorder")
- Home health care (refer to "Home Health Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")
- Physical, occupational, and speech therapy provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")

Rehabilitative and habilitative Services exclusions

- Items and services that are not health care items and services (for example, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including vocational training)

Reproductive Health Services

Family planning Services

We cover the following Services when provided for family planning purposes:

- Family planning counseling
- Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") and office visits related to their insertion, removal, and management when provided to prevent pregnancy
- Female sterilization procedures
- Male sterilization procedures

Abortion and abortion-related Services

We cover the following Services:

- Surgical abortion
- Prescription drugs, in accord with our drug formulary guidelines
- Abortion-related Services

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Services to diagnose or treat infertility (refer to "Fertility Services")
- Office visits related to injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") when provided for medical reasons other than to prevent pregnancy (refer to "Office Visits")
- Outpatient administered drugs that are not contraceptives (refer to "Administered Drugs and Products")
- Outpatient laboratory and imaging services associated with family planning services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient contraceptive drugs and devices (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient surgery and outpatient procedures when provided for medical reasons other than to prevent pregnancy (refer to "Outpatient Surgery and Outpatient Procedures")

Reproductive health Services exclusions

- Reversal of voluntary sterilization

Services in Connection with a Clinical Trial

We cover Services you receive in connection with a clinical trial if all of the following requirements are met:

- We would have covered the Services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
  - ♦ a Plan Provider makes this determination
  - ♦ you provide us with medical and scientific information establishing this determination
- If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition, and that meets one of the following requirements:

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application
- The study or investigation is approved or funded by at least one of the following:
  - ♦ the National Institutes of Health
  - ♦ the Centers for Disease Control and Prevention
  - ♦ the Agency for Health Care Research and Quality
  - ♦ the Centers for Medicare & Medicaid Services
  - ♦ a cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
  - ♦ a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - ♦ the Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review

For covered Services related to a clinical trial, you will pay the Cost Share you would pay if the Services were not related to a clinical trial. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

Services in connection with a clinical trial exclusions

- The investigational Service

- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management

Skilled Nursing Facility Care

Inside our Service Area, we cover skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our prior authorization procedure if Skilled Nursing Facilities ordinarily furnish the equipment (refer to "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Whole blood, red blood cells, plasma, platelets, and their administration
- Medical supplies
- Behavioral health treatment that is Medically Necessary to treat mental health conditions that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that are listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*
- Physical, occupational, and speech therapy
- Respiratory therapy

For the following Services, refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy (refer to "Rehabilitative and Habilitative Services")

Substance Use Disorder Treatment

We cover Services specified in this "Substance Use Disorder Treatment" section only when the Services are for the prevention, diagnosis, or treatment of Substance Use Disorders. A "Substance Use Disorder" is a substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Outpatient substance use disorder treatment

We cover the following Services for treatment of substance use disorders:

- Day-treatment programs
- Individual and group substance use disorder counseling
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder treatment, the Services are generally and customarily provided by a substance use disorder residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group substance use disorder counseling
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Discharge planning

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section). For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Telehealth Visits

Telehealth Visits are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You may receive covered Services via Telehealth Visits, when available and if the Services would have been covered under this *EOC* if provided in person. You are not required to use Telehealth Visits, and you may choose to receive in-person Services from a Plan Provider instead. Some Plan Providers offer Services exclusively through a telehealth technology platform and have no physical location at which you can receive Services. If you receive covered Services from these Plan Providers, you may access your medical record of the Telehealth Visit and, unless you object, such information will be added to your Health Plan electronic medical record and shared with your Primary Care Physician.

We cover the following types of Telehealth Visits with Primary Care Physicians, Non-Physician Specialists, and Physician Specialists:

- Interactive video visits
- Scheduled telephone visits

Transplant Services

We cover transplants of organs, tissue, or bone marrow if the Medical Group provides a written referral for care to a transplant facility as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

After the referral to a transplant facility, the following applies:

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Please call Member Services for questions about donor Services

For covered transplant Services that you receive, you will pay the Cost Share you would pay if the Services were not related to a transplant. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services. We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor Services at **no charge**.

For the following Services, refer to these sections

- Dental Services that are Medically Necessary to prepare for a transplant (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")

Vision Services for Adult Members

For the purpose of this "Vision Services for Adult Members" section, an "Adult Member" is a Member who is age 19 or older and is not a Pediatric Member, as defined under "Vision Services for Pediatric Members" in this "Benefits" section. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1.

We cover the following for Adult Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this "Vision Services for Adult Members" section).

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Adult Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)

Vision Services for Adult Members exclusions

- Contact lenses, including fitting and dispensing, except as described under this "Vision Services for Adult Members" section
- Eyeglass lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

Vision Services for Pediatric Members

For the purpose of this "Vision Services for Pediatric Members" section, a "Pediatric Member" is a Member from birth through the end of the month of their 19th birthday. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1 and your last minute as a Pediatric Member will be 11:59 p.m. on June 30.

We cover the following for Pediatric Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this "Vision Services for Pediatric Members" section).

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Pediatric Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)

Vision Services for Pediatric Members exclusions

- Contact lenses, including fitting and dispensing, except as described under this "Vision Services for Pediatric Members" section
- Eyeglass lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *EOC* regardless of whether the services are within the scope of a provider's license or certificate. These exclusions or limitations do not apply to Services that are Medically Necessary to treat mental health conditions or substance use disorders that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that are listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Certain exams and Services

Routine physical exams and other Services that are not Medically Necessary, such as when required (1) for obtaining or maintaining employment or participation in employee programs, (2) for insurance, credentialing or licensing, (3) for travel, or (4) by court order or for parole or probation.

Chiropractic Services

Chiropractic Services and the Services of a chiropractor, unless you have coverage for supplemental chiropractic Services as described in an amendment to this *EOC*.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, including cosmetic surgery (surgery that is performed to alter or reshape normal structures of the body in order to improve appearance), except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Benefits" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after removal of all or part of a breast, and prostheses to replace all or part of an external facial body part

Custodial care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, Skilled Nursing Facility, or hospital inpatient Services.

Dental and orthodontic Services

Dental and orthodontic Services such as X-rays, appliances, implants, Services provided by dentists or orthodontists, dental Services following accidental injury to teeth, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to the following Services:

- Services covered under "Dental and Orthodontic Services" in the "Benefits" section
- Service described under "Injury to Teeth" in the "Benefits" section

- Pediatric dental Services described in a Pediatric Dental Services Amendment to this *EOC*, if any. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC's* Table of Contents

Disposable supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies.

This exclusion does not apply to disposable supplies covered under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits" section.

Experimental or investigational Services

A Service is experimental or investigational if we, in consultation with the Medical Group, determine that one of the following is true:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)
- It requires government approval that has not been obtained when the Service is to be provided

This exclusion does not apply to any of the following:

- Experimental or investigational Services when an investigational application has been filed with the federal Food and Drug Administration ("FDA") and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services in Connection with a Clinical Trial" in the "Benefits" section

Refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Hair loss or growth treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," and "Hospice Care" in the "Benefits" section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services for the purpose of increasing academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Home Health Care," "Hospice Services," "Hospital Inpatient Services," "Rehabilitative and Habilitative Services," or "Skilled Nursing Facility Care" in the "Benefits" section

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Massage therapy

Massage therapy, except that this exclusion does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Home Health Care," "Hospice Services," "Hospital Inpatient

Services," "Rehabilitative and Habilitative Services," or "Skilled Nursing Facility Care" in the "Benefits" section.

Oral nutrition

Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food.

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits" section
- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits" section

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, or inpatient respite care covered in the "Hospice Care" section.

Routine foot care items and services

Routine foot care items and services that are not Medically Necessary.

Services not approved by the federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other Services that by law require federal Food and Drug Administration ("FDA") approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to Services provided anywhere, even outside the U.S.

This exclusion does not apply to any of the following:

- Services covered under the "Emergency Services and Urgent Care" section that you receive outside the U.S.
- Experimental or investigational Services when an investigational application has been filed with the FDA and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services in Connection with a Clinical Trial" in the "Benefits" section

Refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Services performed by unlicensed people

Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Refer to "Surrogacy Arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses

Travel and lodging expenses, except as described in our Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest hospital as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

Coordination of Benefits

The Services covered under this *EOC* are subject to coordination of benefits rules.

Coverage other than Medicare coverage

If you have medical or dental coverage under another plan that is subject to coordination of benefits, we will coordinate benefits with the other coverage under the coordination of benefits rules of the California Department of Managed Health Care. Those rules are incorporated into this *EOC*.

If both the other coverage and we cover the same Service, the other coverage and we will see that up to 100 percent of your covered medical expenses are paid for that Service. The coordination of benefits rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If your coverage under this *EOC* is secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during a calendar year to pay for your out-of-pocket expenses for Services that are partially covered by either your other coverage or us during that calendar year. If you are entitled to a Benefit Reserve Account, we will provide you with detailed information about this account.

If you have any questions about coordination of benefits, please call Member Services.

Medicare coverage

If you have Medicare coverage, we will coordinate benefits with the Medicare coverage under Medicare rules. Medicare rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." You must give us any information we request to help us coordinate benefits. Please call Member Services to find out which Medicare rules apply to your situation, and how payment will be handled.

Reductions

Employer responsibility

For any Services that the law requires an employer to provide, we will not pay the employer, and when we cover any such Services we may recover the value of the Services from the employer.

Government agency responsibility

For any Services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such Services we may recover the value of the Services from the government agency.

Injuries or illnesses alleged to be caused by other parties

If you obtain a judgment or settlement from or on behalf of another party who allegedly caused an injury or illness for which you received covered Services, you must reimburse us to the maximum extent allowed under California Civil Code Section 3040. The reimbursement due to us is not limited by or subject to the Plan Out-of-Pocket Maximum. Note: This "Injuries or illnesses alleged to be caused by other parties" section does not affect your obligation to pay your Cost Share for these Services.

To the extent permitted or required by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien on the proceeds of any judgment or settlement you or we obtain against another party. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred.

Within 30 days after submitting or filing a claim or legal action against another party, you must send written notice of the claim or legal action to:

Equian
Kaiser Permanente - Northern California Region
Subrogation Mailbox
P.O. Box 36380
Louisville, KY 40233
Fax: 1-502-214-1137

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the other party, and the other party's liability insurer to pay us

directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against another party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

If you have Medicare, Medicare law may apply with respect to Services covered by Medicare.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers ordinarily charge to the general public ("General Fees"). However, these contracts may allow the providers to recover all or a portion of the difference between the fees paid by Kaiser Permanente and their General Fees by means of a lien claim under California Civil Code Sections 3045.1-3045.6 against a judgment or settlement that you receive from or on behalf of another party. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive payments or other compensation under the Surrogacy Arrangement, you must reimburse us for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") to the maximum extent allowed under California Civil Code Section 3040. Note: This "Surrogacy Arrangements" section does not affect your obligation to pay your Cost Share for these Services. After you surrender a baby to the legal parents, you are not obligated to reimburse us for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and phone numbers of the other parties to the arrangement
- Names, addresses, and phone numbers of any escrow agent or trustee
- Names, addresses, and phone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and phone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian
Kaiser Permanente - Northern California Region
Surrogacy Mailbox
P.O. Box 36380
Louisville, KY 40233
Fax: 1-502-214-1137

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this "Surrogacy Arrangements" section without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against another party based on the Surrogacy Arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

If you have questions about your obligations under this provision, please call Member Services.

U.S. Department of Veterans Affairs

For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such Services we may recover the value of the Services from the Department of Veterans Affairs.

Workers' compensation or employer's liability benefits

You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered Services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law

Post-Service Claims and Appeals

This "Post-Service Claims and Appeals" section explains how to file a claim for payment or reimbursement for Services that you have already received. Please use the procedures in this section in the following situations:

- You have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services from a Non–Plan Provider and you want us to pay for the Services
- You have received Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services) and you want us to pay for the Services
- You want to appeal a denial of an initial claim for payment

Please follow the procedures under "Grievances" in the "Dispute Resolution" section in the following situations:

- You want us to cover Services that you have not yet received
- You want us to continue to cover an ongoing course of covered treatment
- You want to appeal a written denial of a request for Services that require prior authorization (as described under "Medical Group authorization procedure for certain referrals")

Who May File

The following people may file claims:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a claim for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the claim
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the claim
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services office at a Plan Facility, on our website at **kp.org**, or by calling Member Services. Your written authorization must accompany the claim. You must pay the cost of anyone you hire to represent or help you.

Supporting Documents

You can request payment or reimbursement orally or in writing. Your request for payment or reimbursement, and any related documents that you give us, constitute your claim.

Claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

To file a claim in writing for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services, please use our claim form. You can obtain a claim form in the following ways:

- By visiting our website at **kp.org**

- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

Claims forms for all other Services

To file a claim in writing for all other Services, you may use our grievance form. You can obtain this form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

Other supporting information

When you file a claim, please include any information that clarifies or supports your position. For example, if you have paid for Services, please include any bills and receipts that support your claim. To request that we pay a Non–Plan Provider for Services, include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will file the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. When appropriate, we will request medical records from Plan Providers on your behalf. If you tell us that you have consulted with a Non–Plan Provider and are unable to provide copies of relevant medical records, we will contact the provider to request a copy of your relevant medical records. We will ask you to provide us a written authorization so that we can request your records.

If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should follow the steps in the written notice sent to you about your claim.

Initial Claims

To request that we pay a provider (or reimburse you) for Services that you have already received, you must file a claim. If you have any questions about the claims process, please call Member Services.

Submitting a claim for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

You may file a claim (request for payment/reimbursement):

- By visiting **kp.org**, completing an electronic form and uploading supporting documentation;
- By mailing a paper form that can be obtained by visiting **kp.org** or calling Member Services; or
- If you are unable access the electronic form (or obtain the paper form), by mailing the minimum amount of information we need to process your claim:
  - Member/Patient Name and Medical/Health Record Number
  - The date you received the Services
  - Where you received the Services
  - Who provided the Services
  - Why you think we should pay for the Services
  - A copy of the bill, your medical record(s) for these Services, and your receipt if you paid for the Services

Mailing address to submit your claim to Kaiser Permanente:

Kaiser Permanente
Claims Administration - NCAL
P.O. Box 12923
Oakland, CA 94604-2923

Please call Member Services if you need help filing your claim.

Submitting a claim for all other Services

If you have received Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services), then as soon as possible after you receive the Services, you must file your claim in one of the following ways:

- By delivering your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By mailing your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Please call Member Services if you need help filing your claim.

After we receive your claim

We will send you an acknowledgment letter within five days after we receive your claim.

After we review your claim, we will respond as follows:

- If we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim
- If we need more information, we will ask you for the information before the end of the initial 30-day decision period. We will send our written decision no later than 15 days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in our letter, we will make our decision based on the information we have within 15 days after the end of that timeframe

If we pay any part of your claim, we will subtract applicable Cost Share from any payment we make to you or the Non–Plan Provider. You are not responsible for any amounts beyond your Cost Share for covered Emergency Services. If we deny your claim (if we do not agree to pay for all the Services you requested other than the applicable Cost Share), our letter will explain why we denied your claim and how you can appeal.

If you later receive any bills from the Non–Plan Provider for covered Services (other than bills for your Cost Share), please call Member Services for assistance.

Appeals

Claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services from a Non–Plan Provider

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By mailing your appeal to the Claims Department at the following address:

  Kaiser Foundation Health Plan, Inc.
  Special Services Unit
  P.O. Box 23280
  Oakland, CA 94623

- By calling Member Services at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Claims for Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services)

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By visiting our website at **kp.org**
- By mailing your appeal to any Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- In person at any Member Services office at a Plan Facility or any Plan Provider (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

When you file an appeal, please include any information that clarifies or supports your position. If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Additional information regarding a claim for Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services)

If we initially denied your request, you must file your appeal within 180 days after the date you received our denial letter. You may send us information including comments, documents, and medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send all additional information to the address or fax mentioned in your denial letter.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter, sent to you within five days after we receive your appeal. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will review it without regard to whether this information was filed or considered in our initial decision regarding your request for Services. You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our final decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

We will send you a resolution letter within 30 days after we receive your appeal. If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

External Review

You must exhaust our internal claims and appeals procedures before you may request external review unless we have failed to comply with the claims and appeals procedures described in this "Post-Service Claims and Appeals" section. For information about the external review process, see "Independent Medical Review ("IMR")" in the "Dispute Resolution" section.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA** (**1-866-444-3272**)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Dispute Resolution

We are committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with our Member Services representatives at most Plan Facilities, or you can call Member Services.

Grievances

This "Grievances" section describes our grievance procedure. A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. If you want to make a claim for payment or reimbursement for Services that you have already received from a Non–Plan Provider, please follow the procedure in the "Post-Service Claims and Appeals" section.

Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received
- You received a written denial of Services that require prior authorization from the Medical Group and you want us to cover the Services
- You received a written denial for a second opinion or we did not respond to your request for a second opinion in an expeditious manner, as appropriate for your condition
- Your treating physician has said that Services are not Medically Necessary and you want us to cover the Services
- You were told that Services are not covered and you believe that the Services should be covered
- You want us to continue to cover an ongoing course of covered treatment
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- You believe you have faced discrimination from providers, staff, or Health Plan
- We terminated your membership and you disagree with that termination

Who may file

The following people may file a grievance:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a grievance for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the grievance
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the grievance
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal
- Your physician may act as your authorized representative with your verbal consent to request an urgent grievance as described under "Urgent procedure" in this "Grievances" section

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services office at a Plan Facility, on our website at **kp.org**, or by calling Member Services. Your written authorization must accompany the grievance. You must pay the cost of anyone you hire to represent or help you.

How to file

You can file a grievance orally or in writing. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the Services you received.

Standard Procedure

To file a grievance electronically, use the grievance form on **kp.org**.

To file a grievance orally, call Member Services toll free at **1-800-464-4000** (TTY users call **711**).

To file a grievance in writing, please use our grievance form, which is available on **kp.org** under "Forms & Publications," in person from any Member Services office at a Plan Facility, or from Plan Providers (for addresses, refer to our Provider Directory or call Member Services). You can submit the form in the following ways:

- In person at any Member Services office at a Plan Facility
- By mail to any Member Services office at a Plan Facility

You must file your grievance within 180 days following the incident or action that is subject to your dissatisfaction. You may send us information including comments, documents, and medical records that you believe support your grievance.

Please call Member Services if you need help filing a grievance.

If your grievance involves a request to obtain a non-formulary prescription drug, we will notify you of our decision within 72 hours. If we do not decide in your favor, our letter will explain why and describe your further appeal rights. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non-Formulary Prescription Drug Requests" in this "Dispute Resolution" section.

For all other grievances, we will send you an acknowledgment letter within five days after we receive your grievance. We will send you a resolution letter within 30 days after we receive your grievance. If you are requesting Services, and we do not decide in your favor, our letter will explain why and describe your further appeal rights.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Urgent procedure

If you want us to consider your grievance on an urgent basis, please tell us that when you file your grievance. Note: Urgent is sometimes referred to as "exigent." If exigent circumstances exist, your grievance may be reviewed using the urgent procedure described in this section.

You must file your urgent grievance in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

Kaiser Foundation Health Plan, Inc.
Expedited Review Unit
P.O. Box 23170
Oakland, CA 94623-0170

- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By completing the grievance form on our website at **kp.org**

We will decide whether your grievance is urgent or non-urgent unless your attending health care provider tells us your grievance is urgent. If we determine that your grievance is not urgent, we will use the procedure described under "Standard procedure" in this "Grievances" section. Generally, a grievance is urgent only if one of the following is true:

- Using the standard procedure could seriously jeopardize your life, health, or ability to regain maximum function
- Using the standard procedure would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment
- A physician with knowledge of your medical condition determines that your grievance is urgent
- You have received Emergency Services but have not been discharged from a facility and your request involves admissions, continued stay, or other health care Services
- You are undergoing a current course of treatment using a non-formulary prescription drug and your grievance involves a request to refill a non-formulary prescription drug

For most grievances that we respond to on an urgent basis, we will give you oral notice of our decision as soon as your clinical condition requires, but no later than 72 hours after we received your grievance. We will send you a written confirmation of our decision within three days after we received your grievance.

If your grievance involves a request to obtain a non-formulary prescription drug and we respond to your request on an urgent basis, we will notify you of our decision within 24 hours of your request. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non- Formulary Prescription Drug Requests" in this "Dispute Resolution" section.

If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care at any time at **1-888-466-2219** (TDD **1-877-688-9891**) without first filing a grievance with us.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Additional information regarding pre-service requests for Medically Necessary Services

You may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your grievance file and we will consider it in our decision regarding your pre-service request for Medically Necessary Services.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your grievance is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your grievance file.

Additional information regarding appeals of written denials for Services that require prior authorization

You must file your appeal within 180 days after the date you received our denial letter.

You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your appeal.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address

mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will consider it in our decision regarding your appeal.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your appeal is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

Independent Review Organization for Non-Formulary Prescription Drug Requests

If you filed a grievance to obtain a non-formulary prescription drug and we did not decide in your favor, you may submit a request for a review of your grievance by an independent review organization ("IRO"). You must submit your request for IRO review within 180 days of the receipt of our decision letter.

You must file your request for IRO review in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By completing the grievance form on our website at **kp.org**

For urgent IRO reviews, we will forward to you the independent reviewer's decision within 24 hours. For non-urgent requests, we will forward the independent reviewer's decision to you within 72 hours. If the independent reviewer does not decide in your favor, you may submit a complaint to the Department of Managed Health Care, as described under "Department of Managed Health Care Complaints" in this "Dispute Resolution" section. You may also submit a request for an Independent Medical Review as described under "Independent Medical Review" in this "Dispute Resolution" section.

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **1-800-464-4000** (TTY users call **711**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review ("IMR")

Except as described in this "Independent Medical Review ("IMR")" section, you must exhaust our internal grievance procedure before you may request independent medical review unless we have failed to comply with the grievance procedure described under "Grievances" in this "Dispute Resolution" section. If you qualify, you or your authorized representative may have your issue reviewed through the IMR process managed by the California Department of Managed Health Care

("DMHC"). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against us.

You may qualify for IMR if all of the following are true:

- One of these situations applies to you:
  - ♦ you have a recommendation from a provider requesting Medically Necessary Services
  - ♦ you have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary
  - ♦ you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function. If we have denied your grievance, you must submit your request for an IMR within six months of the date of our written denial. However, the DMHC may accept your request after six months if they determine that circumstances prevented timely submission

You may also qualify for IMR if the Service you requested has been denied on the basis that it is experimental or investigational as described under "Experimental or investigational denials."

If the DMHC determines that your case is eligible for IMR, it will ask us to send your case to the DMHC's IMR organization. The DMHC will promptly notify you of its decision after it receives the IMR organization's determination. If the decision is in your favor, we will contact you to arrange for the Service or payment.

Experimental or investigational denials

If we deny a Service because it is experimental or investigational, we will send you our written explanation within three days after we received your request. We will explain why we denied the Service and provide additional dispute resolution options. Also, we will provide information about your right to request Independent Medical Review if we had the following information when we made our decision:

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested. "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity
- If your treating physician is a Plan Physician, they recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying their recommendation
- You (or your Non–Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying their recommendation. We do not cover the Services of the Non–Plan Provider

Note: You can request IMR for experimental or investigational denials at any time without first filing a grievance with us.

Office of Civil Rights Complaints

If you believe that you have been discriminated against by a Plan Provider or by us because of your race, color, national origin, disability, age, sex (including sex stereotyping and gender identity), or religion, you may file a complaint with the Office of Civil Rights in the United States Department of Health and Human Services ("OCR").

You may file your complaint with the OCR within 180 days of when you believe the act of discrimination occurred. However, the OCR may accept your request after six months if they determine that circumstances prevented timely submission. For more information on

the OCR and how to file a complaint with the OCR, go to **hhs.gov/civil-rights**.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA** (**1-866-444-3272**)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Binding Arbitration

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *EOC*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. ("Health Plan"), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- Governing law does not prevent the use of binding arbitration to resolve the claim

Members enrolled under this *EOC* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

As referred to in this "Binding Arbitration" section, "Member Parties" include:

- A Member
- A Member's heir, relative, or personal representative
- Any person claiming that a duty to them arises from a Member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Rules of Procedure

Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") developed by the Office of the Independent Administrator in consultation with Kaiser

Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Member Services.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and phone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include in the Demand for Arbitration all claims against Respondents that are based on the same incident, transaction, or related circumstances.

Serving Demand for Arbitration

Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department
1950 Franklin St., 17th Floor
Oakland, CA 94612

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Member Services.

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing after a dispute has arisen and a request for binding arbitration has been submitted that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondent served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the

neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with another party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2024, your last minute of coverage was at 11:59 p.m. on December 31, 2023). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, your Group will notify you of the date that your membership will end. Your membership termination date is the first day you are not covered. For example, if your termination date is January 1, 2024, your last minute of coverage was at 11:59 p.m. on December 31, 2023.

Termination of *Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Termination for Cause

If you intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider, we may terminate your membership by sending written notice to the Subscriber; termination will be effective 30 days from the date we send the notice. Some examples of fraud include:

- Misrepresenting eligibility information about you or a Dependent
- Presenting an invalid prescription or physician order
- Misusing a Kaiser Permanente ID card (or letting someone else use it)
- Giving us incorrect or incomplete material information. For example, you have entered into a Surrogacy Arrangement and you fail to send us the information we require under "Surrogacy Arrangements" under "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section
- Failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

Termination of a Product or all Products

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the

group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

If we terminate your membership for cause or for nonpayment, we will:

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Emergency Services and Urgent Care" and "Dispute Resolution" sections

We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you.

State Review of Membership Termination

If you believe that we have terminated your membership because of your ill health or your need for care, you may request a review of the termination by the California Department of Managed Health Care (please see "Department of Managed Health Care Complaints" in the "Dispute Resolution" section).

Continuation of Membership

If your membership under this *EOC* ends, you may be eligible to continue Health Plan membership without a break in coverage. You may be able to continue Group coverage under this *EOC* as described under "Continuation of Group Coverage." Also, you may be able to continue membership under an individual plan as described under "Continuation of Coverage under an Individual Plan." If at any time you become entitled to continuation of Group coverage, please examine your coverage options carefully before declining this coverage. Individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

Continuation of Group Coverage

COBRA

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

If you enroll in COBRA and exhaust the time limit for COBRA coverage, you may be able to continue Group coverage under state law as described under "Cal-COBRA" in this "Continuation of Group Coverage" section.

Cal-COBRA

If you are eligible for coverage under the California Continuation Benefits Replacement Act ("Cal-COBRA"), you can continue coverage as described in this "Cal-COBRA" section if you apply for coverage in compliance with Cal-COBRA law and pay applicable Premiums.

Eligibility and effective date of coverage for Cal-COBRA after COBRA

If your group is subject to COBRA and your COBRA coverage ends, you may be able to continue Group coverage effective the date your COBRA coverage ends if all of the following are true:

- Your effective date of COBRA coverage was on or after January 1, 2003
- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You do not have Medicare

You must request an enrollment application by calling Member Services within 60 days of the date of when your COBRA coverage ends.

Cal-COBRA enrollment and Premiums

Within 10 days of your request for an enrollment application, we will send you our application, which will include Premium and billing information. You must

return your completed application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay Full Premiums within 45 days after the date we issue the bill. The first Premium payment will include coverage from your Cal-COBRA effective date through our current billing cycle. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

After that first payment, your Premium payment for the upcoming coverage month is due on first day of that month. The Premiums will not exceed 110 percent of the applicable Premiums charged to a similarly situated individual under the Group benefit plan except that Premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent. Returned checks or insufficient funds on electronic payments will be subject to a $25 fee.

If you have selected Ancillary Coverage provided under any other program, the Premium for that Ancillary Coverage will be billed together with required Premiums for coverage under this *EOC*. Full Premiums will then also include Premium for Ancillary Coverage. This means if you do not pay the Full Premiums owed by the due date, we may terminate your membership under this *EOC* and any Ancillary Coverage, as described in the "Termination for nonpayment of Cal-COBRA Premiums" section.

Changes to Cal-COBRA coverage and Premiums
Your Cal-COBRA coverage is the same as for any similarly situated individual under your Group's *Agreement*, and your Cal-COBRA coverage and Premiums will change at the same time that coverage or Premiums change in your Group's *Agreement*. Your Group's coverage and Premiums will change on the renewal date of its *Agreement* (January 1), and may also change at other times if your Group's *Agreement* is amended. Your monthly invoice will reflect the current Premiums that are due for Cal-COBRA coverage, including any changes. For example, if your Group makes a change that affects Premiums retroactively, the amount we bill you will be adjusted to reflect the retroactive adjustment in Premiums. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended. You can also request one from Member Services.

Cal-COBRA open enrollment or termination of another health plan
If you previously elected Cal-COBRA coverage through another health plan available through your Group, you may be eligible to enroll in Kaiser Permanente during your Group's annual open enrollment period, or if your Group terminates its agreement with the health plan you are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA. Please ask your Group for information about health plans available to you either at open enrollment or if your Group terminates a health plan's agreement.

In order for you to switch from another health plan and continue your Cal-COBRA coverage with us, we must receive your enrollment application during your Group's open enrollment period, or within 63 days of receiving the Group's termination notice described under "Group responsibilities." To request an application, please call Member Services. We will send you our enrollment application and you must return your completed application before open enrollment ends or within 63 days of receiving the termination notice described under "Group responsibilities." If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

How you may terminate your Cal-COBRA coverage
You may terminate your Cal-COBRA coverage by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the last day of the month in which we receive your notice. Also, you must include with your notice all amounts payable related to your Cal-COBRA coverage, including Premiums, for the period prior to your termination date.

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23127
San Diego, CA 92193-3127

Termination for nonpayment of Cal-COBRA Premiums
If you do not pay Full Premiums by the due date, we may terminate your membership as described in this "Termination for nonpayment of Cal-COBRA Premiums" section. If you intend to terminate your membership, be sure to notify us as described under "How you may terminate your Cal-COBRA coverage" in this "Cal-COBRA" section, as you will be responsible for any Premiums billed to you unless you let us know

before the first of the coverage month that you want us to terminate your coverage.

Your Premium payment for the upcoming coverage month is due on the first day of that month. If we do not receive Full Premium payment on or before the first day of the coverage month, we will send a notice of nonreceipt of payment to the Subscriber's address of record. You will have a 30-day grace period to pay the required Premiums before we terminate your Cal-COBRA coverage for nonpayment. The notice will state when the grace period begins and when the memberships of the Subscriber and all Dependents will terminate if the required Premiums are not paid. Your coverage will continue during this grace period. If we do not receive Full Premium payment by the end of the grace period, we will mail a termination notice to the Subscriber's address of record. After termination of your membership for nonpayment of Cal-COBRA Premiums, you are still responsible for paying all amounts due, including Premiums for the grace period.

Reinstatement of your membership after termination for nonpayment of Cal-COBRA Premiums

If we terminate your membership for nonpayment of Premiums, we will permit reinstatement of your membership three times during any 12-month period if we receive the amounts owed within 15 days of the date of the Termination Notice. We will not reinstate your membership if you do not obtain reinstatement of your terminated membership within the required 15 days, or if we terminate your membership for nonpayment of Premiums more than three times in a 12-month period.

Termination of Cal-COBRA coverage

Cal-COBRA coverage continues only upon payment of applicable monthly Premiums to us at the time we specify, and terminates on the earliest of:

- The date your Group's *Agreement* with us terminates (you may still be eligible for Cal-COBRA through another Group health plan)
- The date you get Medicare
- The date your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied)
- The date that is 36 months after your original COBRA effective date (under this or any other plan)
- The date your membership is terminated for nonpayment of Premiums as described under "Termination for nonpayment of Cal-COBRA Premiums" in this "Continuation of Membership" section

Note: If the Social Security Administration determined that you were disabled at any time during the first 60 days of COBRA coverage, you must notify your Group within 60 days of receiving the determination from Social Security. Also, if Social Security issues a final determination that you are no longer disabled in the 35th or 36th month of Group continuation coverage, your Cal-COBRA coverage will end the later of: (1) expiration of 36 months after your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security issued its final determination. You must notify us within 30 days after you receive Social Security's final determination that you are no longer disabled.

Group responsibilities

If your Group's agreement with a health plan is terminated, your Group is required to provide written notice at least 30 days before the termination date to the persons whose Cal-COBRA coverage is terminating. This notice must inform Cal-COBRA beneficiaries that they can continue Cal-COBRA coverage by enrolling in any health benefit plan offered by your Group. It must also include information about benefits, premiums, payment instructions, and enrollment forms (including instructions on how to continue Cal-COBRA coverage under the new health plan). Your Group is required to send this information to the person's last known address, as provided by the prior health plan. Health Plan is not obligated to provide this information to qualified beneficiaries if your Group fails to provide the notice. These persons will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA.

USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal Uniformed Services Employment and Reemployment Rights Act ("USERRA"). You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group to find out how to elect USERRA coverage and how much you must pay your Group.

Coverage for a Disabling Condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement* with us terminated
- You are no longer Totally Disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *EOC*, including Cost Share, but we will not cover Services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call Member Services within 30 days after your Group's *Agreement* with us terminates.

Continuation of Coverage under an Individual Plan

If you want to remain a Health Plan member when your Group coverage ends, you might be able to enroll in one of our Kaiser Permanente for Individuals and Families plans. The premiums and coverage under our individual plan coverage are different from those under this *EOC*.

If you want your individual plan coverage to be effective when your Group coverage ends, you must submit your application within the special enrollment period for enrolling in an individual plan due to loss of other coverage. Otherwise, you will have to wait until the next annual open enrollment period.

To request an application to enroll directly with us, please go to **buykp.org** or call Member Services. For information about plans that are available through Covered California, see "Covered California" below.

Covered California

U.S. citizens or legal residents of the U.S. can buy health care coverage from Covered California. This is California's health benefit exchange ("the Exchange"). You may apply for help to pay for premiums and copayments but only if you buy coverage through Covered California. This financial assistance may be available if you meet certain income guidelines. To learn more about coverage that is available through Covered California, visit **CoveredCA.com** or call Covered California at **1-800-300-1506** (TTY users call **711**).

Miscellaneous Provisions

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement*, including this *EOC*.

Advance Directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including the following:

- A *Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments
- *Individual health care instructions* let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that included in your medical chart

To learn more about advance directives, including how to obtain forms and instructions, contact the Member Services office at a Plan Facility. For more information about advance directives, refer to our website at **kp.org** or call Member Services.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to inform you in accord with applicable law and your Group's *Agreement*.

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *EOC*.

Assignment

You may not assign this *EOC* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

Attorney and Advocate Fees and Expenses

In any dispute between a Member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC* and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*. We may use medical experts to help us review claims. If coverage under this *EOC* is subject to the Employee Retirement Income Security Act ("ERISA") claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *EOC*.

EOC Binding on Members

By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

ERISA Notices

This "ERISA Notices" section applies only if your Group's health benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *EOC*.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, 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. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Share applicable to other medical and surgical benefits provided under this plan.

Governing Law

Except as preempted by federal law, this *EOC* will be governed in accord with California law and any provision that is required to be in this *EOC* by state or federal law shall bind Members and Health Plan whether or not set forth in this *EOC*.

Group and Members Not Our Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

No Waiver

Our failure to enforce any provision of this *EOC* will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Notices Regarding Your Coverage

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible

for notifying us of any change in address. Subscribers who move should call Member Services as soon as possible to give us their new address. If a Member does not reside with the Subscriber, or needs to have confidential information sent to an address other than the Subscriber's address, they should call Member Services to discuss alternate delivery options.

Note: When we tell your Group about changes to this *EOC* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days (or five days if we terminate your Group's *Agreement*) after receiving the information from us. The Subscriber is also responsible for notifying Group of any change in contact information.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means. You may request confidential communication by completing a confidential communication request form, which is available on **kp.org** under "Request for confidential communications forms." Your request for confidential communication will be valid until you submit a revocation or a new request for confidential communication. If you have questions, please call Member Services.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions. In addition, protected health information is shared with your Group only with your authorization or as otherwise permitted by law.

We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. OUR *NOTICE OF PRIVACY PRACTICES*, WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy, please call Member Services. You can also find the notice at a Plan Facility or on our website at **kp.org**.

Public Policy Participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our website at **about.kp.org** or from Member Services. If you would like to provide input about Health Plan public policy for consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Helpful Information

How to Obtain this *EOC* in Other Formats

You can request a copy of this *EOC* in an alternate format (Braille, audio, electronic text file, or large print) by calling Member Services.

Provider Directory

Refer to the Provider Directory for your Home Region for the following information:

- A list of Plan Physicians
- The location of Plan Facilities and the types of covered Services that are available from each facility
- Hours of operation
- Appointments and advice phone numbers

This directory is available on our website at **kp.org**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

Online Tools and Resources

Here are some tools and resources available on our website at **kp.org**:

- How to use our Services and make appointments
- Tools you can use to email your doctor's office, view test results, refill prescriptions, and schedule routine appointments
- Health education resources
- Preventive care guidelines
- Member rights and responsibilities

You can also access tools and resources using the KP app on your smartphone or other mobile device.

Document Delivery Preferences

Many Health Plan documents are available electronically, such as bills, statements, and notices. If you prefer to get documents in electronic format, go to **kp.org** or call Member Services. You can change delivery preference at any time. To get a copy of a specific Heath Plan document in printed format, call Member Services.

How to Reach Us

Appointments

If you need to make an appointment, please call us or visit our website:

Call The appointment phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Website **kp.org** for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

If you need advice on whether to get medical care, or how and when to get care, we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week:

Call The appointment or advice phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Member Services

If you have questions or concerns about your coverage, how to obtain Services, or the facilities where you can receive care, you can reach us in the following ways:

Call **1-800-464-4000** (English and more than 150 languages using interpreter services)
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
TTY users call **711**

24 hours a day, seven days a week (except closed holidays)

Visit Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Write Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Website **kp.org**

Estimates, bills, and statements

For the following concerns, please call us at the number below:

- If you have questions about a bill
- To find out how much you have paid toward your Plan Deductible (if applicable) or Plan Out-of-Pocket Maximum
- To get an estimate of Charges for Services that are subject to the Plan Deductible (if applicable)

Call **1-800-464-4000** (TTY users call **711**)

24 hours a day, seven days a week (except closed holidays)

Website **kp.org/memberestimates**

Away from Home Travel Line

If you have questions about your coverage when you are away from home:

Call **1-951-268-3900**

24 hours a day, seven days a week (except closed holidays)

Website **kp.org/travel**

Authorization for Post-Stabilization Care

To request prior authorization for Post-Stabilization Care as described under "Emergency Services" in the "Emergency Services and Urgent Care" section:

Call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card (TTY users call **711**)

24 hours a day, seven days a week

Help with claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

If you need a claim form to request payment or reimbursement for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits" section, or if you need help completing the form, you can reach us by calling or by visiting our website.

Call **1-800-464-4000** (TTY users call **711**)

24 hours a day, seven days a week (except closed holidays)

Website **kp.org**

Submitting claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

If you need to submit a completed claim form for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

Write Kaiser Permanente
Claims Administration - NCAL
P.O. Box 12923
Oakland, CA 94604-2923

Text telephone access ("TTY")

If you use a text telephone device ("TTY," also known as "TDD") to communicate by phone, you can use the California Relay Service by calling **711**.

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call Member Services.

Payment Responsibility

This "Payment Responsibility" section briefly explains who is responsible for payments related to the health care coverage described in this *EOC*. Payment responsibility is more fully described in other sections of the *EOC* as described below:

- Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums if you have COBRA or Cal-COBRA (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section and "COBRA" and "Cal-COBRA" under "Continuation of Group Coverage" in the "Continuation of Membership" section)
- Your Group may require you to contribute to Premiums (your Group will tell you the amount and how to pay)
- You are responsible for paying your Cost Share for covered Services (refer to the "Cost Share Summary" section)
- If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider, or if you receive emergency ambulance Services, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us (refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)
- If you receive Services from Non–Plan Providers that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services) and you want us to pay for the care, you must submit a grievance (refer to "Grievances" in the "Dispute Resolution" section)
- If you have coverage with another plan or with Medicare, we will coordinate benefits with the other coverage (refer to "Coordination of Benefits" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)

- In some situations, you or another party may be responsible for reimbursing us for covered Services (refer to "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- You must pay the full price for noncovered Services

Important Notices

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. You can also request auxiliary aids and devices at our facilities. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: خدمات الترجمة الفورية متوفرة لك مجا ًنا على مدار الساعة كافة أيام األسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. يمكنك أيضاً طلب مساعدات إضافية وأجهزة في مرافقنا. ما عليك سوى االتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام األسبوع)مغلق أيام العطالت(. لمستخدمي خدمة الهاتف النصي يرجي االتصال على الرقم)**711**(.

Armenian: Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Դուք նաև կարող եք խնդրել օժանդակ օգնություններ և սարքեր մեր հաստատություններում: Պարզապես զանգահարեք մեզ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ, շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711**:

Chinese: 您每週 7 天，每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。您還可以在我們的場所內申請使用輔助工具和設備。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日休息）。聽障及語障專線(TTY) 使用者請撥 **711**。

Farsi: خدمات زبانی در 24 ساعت شبانروز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه مدارک به زبان شما و یا به صورتهای دیگر درخواست کنید. شما همچنین می توانید کمکهای جانبی و وسایل .کمکی برای محل اقامت خود درخواست کنید کافیست در 24 ساعت شبانروز و 7 روز هفته)به استثنای روزهای تعطیل(با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران ناشنوا)TTY(با شماره **711** تماس بگیرند.

Hindi: बिना किसी लागत के दुभाबिया सेवाएँ, कदन के 24 घंटे, सप्ताह के सातों कदन उपलब्ध हैं। आप एि दुभाबिये की सेवाओं के बलए, बिना किसी लागत के सामबियों को अपनी भाषा में अनुवाद करवाने के बलए, या वैकबपपि प्रारूपों के बलए अनुरोध कर सिते हैं। आप हमारे सुबवधा-स्थलों में सहायि साधनों और उपिरणों के बलए भी अनुरोध कर सिते हैं। कस के वल हमें **1-800-464-4000** पर, कदन के 24 घंटे, सप्ताह के सातों कदन (छुट्टियों वाले कदन को छोड़ कर) कॉल करें। TTY उपयोगिाा **711** पर कॉल करें।

Hmong: Muaj kec pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Koj kuj thov tau lwm yam kev pab thiab khoom siv hauv peb tej tsev hauj lwm. Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。補助サービスや当施設の機器についてもご相談いただけます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTY ユーザーは **711** にお電話ください。

Khmer: ជំនួយភាសា
គិតគតគិតថលថ្លៃដល់អ្នក ឡើយ
24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។
អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែផ្ទាល់មាត់ ឬការបកប្រែឯកសារ
ប្រែបទ្បើជាភាសាខ្មែរ ឬជាទំរង់ជំនួសទ្បសេងៗទ្បទៀត។
អ្នកក៏អាចស្នើសុំឧបករណ៍ និងបរិក្ខា
រជំនួយទំនាក់ទំនង សរ
បអ្នកពិការនៅទីតាំងរបស់យើងផងដែរ
។ គ្រាន់តែទូរស័ព្ទមកយើង តាមទ្បលេខ 1-
800-464-4000 ប្កូន 24 ម៉ោងក្នុងមួយថ្ងៃ 7
ថ្ងៃក្នុងមួយសប្តាហ៍
(បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ទ្បៅទ្បលេខ 711។

Korean: 요일 및 시간에 관계없이 언어지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스,귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 또한 저희 시설에서 보조기구 및 기기를 요청하실 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000** 번으로 전화하십시오 (공휴일휴무). TTY 사용자번호 **711**.

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມີໃຫ້ໂດຍບໍ່ເສັຽຄ່າແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານສາມາດຮ້ອງຂໍຮັບບໍລິການນາຍພາສາ, ໃຫ້ແປເອກະສານເປັນພາສາຂອງທ່ານ, ຫຼືໃນຮູບແບບອື່ນ. ທ່ານສາມາດຂໍອຸປະກອນຊ່ວຍເສີມ ແລະ ອຸປະກອນຕ່າງໆໃນສະຖານບໍລິການຂອງພວກເຮົາໄດ້.ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ປິດວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທ **711**.

Mien: Mbenc nzoih liouh wang-henh tengx nzie faan waac bun muangx maiv zuqc cuotv zinh nyaanh meih, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm liv baaiz mbenc maaih 7 hnoi. Meih se haih tov heuc tengx lorx faan waac mienh tengx faan waac bun muangx, dorh nyungc horngh jaa-sic mingh faan benx meih nyei waac, a'fai liouh ginv longc benx haaix hoc sou-guv daan yaac duqv. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Kungx douc waac mingh lorx taux yie mbuo yiem njiec naaiv **1-800-464-4000**, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm liv baaiz mbenc maaih 7 hnoi. (hnoi-gec se guon gorn zangc oc). TTY nyei mienh nor douc waac lorx **711**.

Navajo: Doo bik'é asíníłáágóó saad bee ata' hane' bee áká e'elyeed nich'į' ąą'át'é, t'áá áłahjį' jį́įgo dóó tł'ée'go áádóó tsosts'íjí ąą'át'é. Ata' hane' yídííkił, naaltsoos t'áá Diné bizaad bee bik'i' ashchíigo, éí doodago hane' bee didíits'íįłígíí yídííkił. Hane' bee bik'i' di'dîítíįłígíí dóó bee hane' didíits'íįłígíí bína'ídíłkidgo yídííkił. Kojį́ hodiilnih **1-800-464-4000**, t'áá áłahjį', jį́įgo dóó tł'ée'go áádóó tsosts'íjí ąą'át'é. (Dahodílzingóne' doo nida'anish dago éí da'deelkaal). TTY chodayooł'ínígíí kojį́ dahalne' **711**.

Punjabi: ਬਿਨਾਂ ਬਿਸੀ ਲਾਗਤ ਦੇ, ਬਦਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਬਦਨ, ਦੁਭਾਸੀਆ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਿਧ ਹੈ। ਤੁਸੀਂ ਇੱਿ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸਾ ਬਵੱਚ
ਅਨੁਵਾਦ ਿਰਵਾਉਣ ਲਈ, ਜਾਂ ਬਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਬਵੱਚ ਪਰਾਪਤ ਿਰਨ ਲਈ ਿੇਨਤੀ ਿਰ ਸਿਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸੁਬਵਧਾਵਾਂ ਬਵੱਚ ਵੀ ਸਹਾਇਿ ਸਾਧਨਾਂ ਅਤੇ ਉਪਿਰਣਾਂ ਲਈ ਿੇਨਤੀ ਿਰ ਸਿਦੇ ਹਾਂ।
ਿਸ ਬਸਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਬਦਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਬਦਨ (ਛੁਟੀਆਂ ਵਾਲੇ ਬਦਨ ਿੰਦ ਰਬਹੰਦਾ ਹੈ) ਫ਼ੋਨ ਿਰੋ। TTY ਦਾ ਉਪਯੋਗ ਿਰਨ ਵਾਲੇ **711** 'ਤੇ ਫ਼ੋਨ ਿਰਨ।

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Мы также можем помочь вам с вспомогательными средствами и альтернативными форматами. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Tenemos disponible asistencia en su idioma sin ningún costo para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. También puede solicitar recursos para discapacidades en nuestros centros de atención. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (excepto los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Maaari ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumamagit ng TTY ay maaaring tumawag sa **711**.

Thai: มีบริการช่วยเหลือดานภาษาฟรีตลอด 24 ช่วโมง 7 วันต่อสัปดาห์ คุณสามารถ ขอใชบริการล่าม แปลเอกสารเป็ นภาษาของคุณ หรือในรูปแบบอื่นได้ คุณสามารถขออุปกรณ์และเครื่องมือช่วยเหลือไดท้ ีศูนยบริการ ใหความช่วยเหลือของเรา โดยโทรหา เราที่ **1-800-464-4000** ตลอด 24 ช่วโมง 7 วันต่อสัปดาห์ (ยกเวน้ วันหยุดราชการ)
ผูใช้TTY ใหโทร **711**

Ukrainian: Послуги перекладача надаються безкоштовно, цілодобово, 7 днів на тиждень. Ви можете зробити запит на послуги усного перекладача, отримання матеріалів у перекладі мовою, якою володієте, або в альтернативних форматах. Також ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Просто зателефонуйте нам за номером **1-800-464-4000**. Ми працюємо цілодобово, 7 днів на тиждень (крім святкових днів). Номер для користувачів телетайпа: **711**.

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị cũng có thể yêu cầu các phương tiện trợ giúp và thiết bị bổ trợ tại các cơ sở của chúng tôi. Quý vị chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.

Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Service Contact Center at **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week (except closed holidays). If you cannot hear or speak well, please call **711**.

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, or another format, call our Member Service Contact Center and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with Kaiser Permanente if you believe we have failed to provide these services or unlawfully discriminated in another way. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You may also speak with a Member Services representative about the options that apply to you. Please call Member Services if you need help filing a grievance.

You may submit a discrimination grievance in the following ways:

- **By phone:** Call Member Services at **1 800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays)
- **By mail:** Call us at **1 800-464-4000** (TTY **711**) and ask to have a form sent to you
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)
- **Online:** Use the online form on our website at kp.org

You may also contact the Kaiser Permanente Civil Rights Coordinators directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office of Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**
- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or 1-**800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

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

- **Online:** Visit the Office of Civil Rights Complaint Portal at:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Aviso de no discriminación

La discriminación es ilegal. Kaiser Permanente cumple con las leyes de los derechos civiles federales y estatales.

Kaiser Permanente no discrimina ilícitamente, excluye ni trata a ninguna persona de forma distinta por motivos de edad, raza, identificación de grupo étnico, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, género, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, condición médica, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

Kaiser Permanente ofrece los siguientes servicios:

- Ayuda y servicios sin costo a personas con discapacidades para que puedan comunicarse mejor con nosotros, como lo siguiente:
  - ♦ intérpretes calificados de lenguaje de señas,
  - ♦ información escrita en otros formatos (braille, impresión en letra grande, audio, formatos electrónicos accesibles y otros formatos).
- Servicios de idiomas sin costo a las personas cuya lengua materna no es el inglés, como:
  - ♦ intérpretes calificados,
  - ♦ información escrita en otros idiomas.

Si necesita nuestros servicios, llame a nuestra Central de Llamadas de Servicio a los Miembros al **1-800-464-4000** (TTY **711**) las 24 horas del día, los 7 días de la semana (excepto los días festivos). Si tiene deficiencias auditivas o del habla, llame al **711**.

Este documento estará disponible en braille, letra grande, casete de audio o en formato electrónico a solicitud. Para obtener una copia en uno de estos formatos alternativos o en otro formato, llame a nuestra Central de Llamadas de Servicio a los Miembros y solicite el formato que necesita.

Cómo presentar una queja ante Kaiser Permanente

Usted puede presentar una queja por discriminación ante Kaiser Permanente si siente que no le hemos ofrecido estos servicios o lo hemos discriminado ilícitamente de otra forma. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)* para obtener más información. También puede hablar con un representante de Servicio a los Miembros sobre las opciones que se apliquen a su caso. Llame a Servicio a los Miembros si necesita ayuda para presentar una queja.

Puede presentar una queja por discriminación de las siguientes maneras:

- **Por teléfono:** llame a Servicio a los Miembros al **1 800-464-4000** (TTY **711**), las 24 horas del día, los 7 días de la semana (excepto los días festivos)**.**

- **Por correo postal:** llámenos al **1 800-464-4000** (TTY **711**) y pida que se le envíe un formulario**.**
- **En persona:** llene un formulario de Queja o reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte su directorio de proveedores en kp.org/facilities [cambie el idioma a español] para obtener las direcciones).
- **En línea:** utilice el formulario en línea en nuestro sitio web en kp.org/espanol.

También puede comunicarse directamente con el coordinador de derechos civiles (Civil Rights Coordinator) de Kaiser Permanente a la siguiente dirección:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

Cómo presentar una queja ante la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica de California *(Solo para beneficiarios de Medi-Cal)*

También puede presentar una queja sobre derechos civiles ante la Oficina de Derechos Civiles (Office of Civil Rights) del Departamento de Servicios de Atención Médica de California (California Department of Health Care Services) por escrito, por teléfono o por correo electrónico:

- **Por teléfono:** llame a la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica (Department of Health Care Services, DHCS) al **916-440-7370** (TTY **711**).
- **Por correo postal:** llene un formulario de queja o envíe una carta a:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Los formularios de queja están disponibles en:
  http://www.dhcs.ca.gov/Pages/Language_Access.aspx (en inglés).
- **En línea:** envíe un correo electrónico a CivilRights@dhcs.ca.gov**.**

Cómo presentar una queja ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU.

Puede presentar una queja por discriminación ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. (U.S. Department of Health and Human Services). Puede presentar su queja por escrito, por teléfono o en línea:

- **Por teléfono:** llame al **1-800-368-1019** (TTY **711** o al 1-**800-537-7697**).
- **Por correo postal:** llene un formulario de queja o envíe una carta a:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Los formularios de quejas están disponibles en
http://www.hhs.gov/ocr/office/file/index.html (en inglés).

- **En línea:** visite el Portal de quejas de la Oficina de Derechos Civiles en: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** (en inglés).

反歧視聲明

歧視是違反法律的行為。Kaiser Permanente遵守州政府與聯邦政府的民權法。

Kaiser Permanente不因年齡、人種、族群認同、膚色、原國籍、文化背景、祖籍、宗教、生理性別、社會性別、性認同、性表現、性取向、婚姻狀況、身體或精神殘障、病況、付款來源、遺傳資訊、公民身份、母語或移民身份而非法歧視、排斥或差別對待任何人。

Kaiser Permanente提供下列服務：

- 為殘障人士提供免費協助與服務以幫助其更好地與我們溝通，例如：
  - ♦ 合格手語翻譯員
  - ♦ 其他格式的書面資訊（盲文版、大字版、語音版、通用電子格式及其他格式）
- 為母語非英語的人士提供免費語言服務，例如：
  - ♦ 合格口譯員
  - ♦ 其他語言的書面資訊

如果您需要上述服務，請打電話**1-800-464-4000 (**TTY **711)** 給會員服務聯絡中心，每週7天，每天24小時（節假日除外）。如果您有聽力或語言困難，請打電話**711**。

若您提出要求，我們可為您提供本文件的盲文版、大字版、錄音卡帶或電子格式。如要得到上述一種替代格式或其他格式的版本，請打電話給會員服務聯絡中心並索取您需要的格式。

如何向Kaiser Permanente投訴

如果您認為我們未能提供上述服務或有其他形式的非法歧視行為，您可向Kaiser Permanente提出歧視投訴。請參閱您的《承保範圍說明書》*(Evidence of Coverage)* 或《保險證明》*(Certificate of Insurance)* 瞭解詳情。您也可以向會員服務部代表諮詢適用於您的選項。如果您在投訴時需要協助，請打電話給會員服務部。

您可透過下列方式投訴歧視：

- **電話**：打電話**1 800-464-4000 (**TTY **711)** 聯絡會員服務部，每週7天，每天24小時（節假日除外）
- **郵寄**：打電話**1 800-464-4000** (TTY **711)** 與我們聯絡，要求將投訴表寄給您
- **親自提出**：在保險計劃下屬設施的會員服務辦公室填寫投訴或索賠／申請表（請在kp.org/facilities網站的保健業者名錄上查詢地址）
- **線上**：使用kp.org網站上的線上表格

您也可直接與Kaiser Permanente民權事務協調員聯絡，地址如下：

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

如何向加州保健服務部民權辦公室投訴（僅限*Medi-Cal*受益人）

您也可透過書面方式、電話或電子郵件向加州保健服務部民權辦公室提出民權投訴：

- **電話**：打電話**916-440-7370** (TTY **711**) 聯絡保健服務部 (DHCS) 民權辦公室
- **郵寄**：填寫投訴表或寄信至：

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  您可在網站上**http://www.dhcs.ca.gov/Pages/Language_Access.aspx**取得投訴表
- **線上**：發送電子郵件至CivilRights@dhcs.ca.gov

如何向美國健康與民眾服務部民權辦公室投訴

您可向美國健康與民眾服務部民權辦公室提出歧視投訴。您可透過書面、電話或線上提出投訴：

- **電話**：打電話**1-800-368-1019**（TTY **711**或1-**800-537-7697**）
- **郵寄**：填寫投訴表或寄信至：

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  您可在網站上取得投訴表：
  http:www.hhs.gov/ocr/office/file/index.html取得投訴表

- **線上**：訪問民權辦公室投訴入口網站：
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf。

Thông Báo Không Phân Biệt Đối Xử

Phân biệt đối xử là trái với pháp luật. Kaiser Permanente tuân thủ các luật dân quyền của Tiểu Bang và Liên Bang.

Kaiser Permanente không phân biệt đối xử trái pháp luật, loại trừ hay đối xử khác biệt với người nào đó vì lý do tuổi tác, chủng tộc, nhận dạng nhóm sắc tộc, màu da, nguồn gốc quốc gia, nền tảng văn hóa, tổ tiên, tôn giáo, giới tính, nhận dạng giới tính, cách thể hiện giới tính, khuynh hướng giới tính, tình trạng hôn nhân, tình trạng khuyết tật về thể chất hoặc tinh thần, bệnh trạng, nguồn thanh toán, thông tin di truyền, quyền công dân, ngôn ngữ mẹ đẻ hoặc tình trạng nhập cư.

Kaiser Permanente cung cấp các dịch vụ sau:

- Phương tiện hỗ trợ và dịch vụ miễn phí cho người khuyết tật để giúp họ giao tiếp hiệu quả hơn với chúng tôi, chẳng hạn như:
  - ♦ Thông dịch viên ngôn ngữ ký hiệu đủ trình độ
  - ♦ Thông tin bằng văn bản theo các định dạng khác (chữ nổi braille, bản in khổ chữ lớn, âm thanh, định dạng điện tử dễ truy cập và các định dạng khác)
- Dịch vụ ngôn ngữ miễn phí cho những người có ngôn ngữ chính không phải là tiếng Anh, chẳng hạn như:
  - ♦ Thông dịch viên đủ trình độ
  - ♦ Thông tin được trình bày bằng các ngôn ngữ khác

Nếu quý vị cần những dịch vụ này, xin gọi đến Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi theo số **1-800-464-4000** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần (đóng cửa ngày lễ). Nếu quý vị không thể nói hay nghe rõ, vui lòng gọi **711** .

Theo yêu cầu, tài liệu này có thể được cung cấp cho quý vị dưới dạng chữ nổi braille, bản in khổ chữ lớn, băng thu âm hay dạng điện tử. Để lấy một bản sao theo một trong những định dạng thay thế này hay định dạng khác, xin gọi đến Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi và yêu cầu định dạng mà quý vị cần.

Cách đệ trình phàn nàn với Kaiser Permanente

Quý vị có thể đệ trình phàn nàn về phân biệt đối xử với Kaiser Permanente nếu quý vị tin rằng chúng tôi đã không cung cấp những dịch vụ này hay phân biệt đối xử trái pháp luật theo cách khác. Vui lòng tham khảo *Chứng Từ Bảo Hiểm (Evidence of Coverage)* hay *Chứng Nhận Bảo Hiểm (Certificate of Insurance)* của quý vị để biết thêm chi tiết. Quý vị cũng có thể nói chuyện với nhân viên ban Dịch Vụ Hội Viên về những lựa chọn áp dụng cho quý vị. Vui lòng gọi đến ban Dịch Vụ Hội Viên nếu quý vị cần được trợ giúp để đệ trình phàn nàn.

Quý vị có thể đệ trình phàn nàn về phân biệt đối xử bằng các cách sau đây:

- **Qua điện thoại:** Gọi đến ban Dịch Vụ Hội Viên theo số **1-800-464-4000** (TTY **711**) 24 giờ trong ngày, 7 ngày trong tuần (đóng cửa ngày lễ)
- **Qua thư tín:** Gọi chúng tôi theo số **1-800-464-4000** (TTY **711**) và yêu cầu gửi mẫu đơn cho quý vị

- **Trực tiếp:** Hoàn tất mẫu đơn Than Phiền hay Yêu Cầu Thanh Toán/Yêu Cầu Quyền Lợi tại văn phòng dịch vụ hội viên ở một Cơ Sở Thuộc Chương Trình (truy cập danh mục nhà cung cấp của quý vị tại kp.org/facilities để biết địa chỉ)
- **Trực tuyến:** Sử dụng mẫu đơn trực tuyến trên trang mạng của chúng tôi tại kp.org

Quý vị cũng có thể liên hệ trực tiếp với Điều Phối Viên Dân Quyền của Kaiser Permanente theo địa chỉ dưới đây:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

Cách đệ trình phàn nàn với Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế California *(Dành Riêng Cho Người Thụ Hưởng Medi-Cal)*

Quý vị cũng có thể đệ trình than phiền về dân quyền với Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế California bằng văn bản, qua điện thoại hay qua email:

- **Qua điện thoại:** Gọi đến Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế (Department of Health Care Services, DHCS) theo số **916-440-7370** (TTY **711**)
- **Qua thư tín:** Điền mẫu đơn than phiền và hay gửi thư đến:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Mẫu đơn than phiền hiện có tại: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**
- **Trực tuyến:** Gửi email đến CivilRights@dhcs.ca.gov

Cách đệ trình phàn nàn với Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ.

Quý vị cũng có quyền đệ trình than phiền về phân biệt đối xử với Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ. Quý vị có thể đệ trình than phiền bằng văn bản, qua điện thoại hoặc trực tuyến:

- **Qua điện thoại:** Gọi **1-800-368-1019** (TTY **711** hay **1-800-537-7697**)
- **Qua thư tín:** Điền mẫu đơn than phiền và hay gửi thư đến:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Mẫu đơn than phiền hiện có tại
  http:www.hhs.gov/ocr/office/file/index.html

- **Trực tuyến:** Truy cập Cổng Thông Tin Than Phiền của Văn Phòng Dân Quyền tại: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.**

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

EOC #1 - Combined Chiropractic and Acupuncture Services Amendment of the Kaiser Foundation Health Plan, Inc. Evidence of Coverage for
LATITUDE AI LLC DBA LATITUDE AI

Group ID: 606405 Contract: 1 Version: 11 *EOC* Number: 1

February 1, 2023, through December 31, 2023

ASH Plans Customer Service Department
Monday through Friday, 5 a.m. to 6 p.m.
1-800-678-9133 (TTY users call **711**) toll free
ashlink.com/ash/kp

TABLE OF CONTENTS FOR EOC #1

Benefit Highlights

We cover the Services described below, subject to exclusions described in the "Exclusions" section, only if all of the following conditions are satisfied:

- You are a Member on the date that you receive the Services
- ASH Plans has determined that the Services are Medically Necessary, except as described in this Amendment
- You receive the Services from ASH Participating Providers or other licensed providers that ASH contracts to provide covered care, except as described in this Amendment

Professional Services (ASH Participating Provider office visits)	**You Pay**
Chiropractic and acupuncture office visits (up to a combined total of 20 visits per 12-month period)	$15 per visit
Other	**You Pay**
X-rays and laboratory tests that are covered Chiropractic Services	No charge
Chiropractic supports and appliances	Amounts in excess of the $50 Allowance

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, refer to the "Covered Services" and "Exclusions" sections.

Introduction

This document amends your Kaiser Foundation Health Plan, Inc. (Health Plan) *EOC* to add coverage for Chiropractic Services and Acupuncture Services as described in this Combined Chiropractic and Acupuncture Services Amendment ("Amendment"). All provisions of the *EOC* apply to coverage described in this document except for the following sections:

- "How to Obtain Services" (except that the "Completion of Services from Non–Plan Providers" section, or for Kaiser Permanente Senior Advantage Members, the "Termination of a Plan Provider's contract and completion of Services" section, does apply to coverage described in this document)
- "Plan Facilities"
- "Emergency Services and Urgent Care"
- "Benefits"

Kaiser Foundation Health Plan, Inc. contracts with American Specialty Health Plans of California, Inc. ("ASH Plans") to make the network of ASH Participating Providers available to you.

When you need chiropractic care or acupuncture, you have direct access to more than 3,400 licensed chiropractors and more than 2,000 licensed acupuncturists in California. You can obtain covered Services from any ASH Participating Provider without a referral from a Plan Physician. Your Cost Share is due when you receive covered Services.

Definitions

In addition to the terms defined in the "Definitions" section of your Health Plan *EOC*, the following terms, when capitalized and used in any part of this Amendment, have the following meanings:

Acupuncture Services: The stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions and appropriate adjunctive therapies, such as hot/cold packs, infrared heat, or acupressure, when provided during the same course of treatment and in conjunction with acupuncture and when provided by an acupuncturist for the treatment of your Musculoskeletal and Related Disorder, nausea (such as nausea related to chemotherapy, post-surgery nausea, or nausea related to pregnancy), or joint pain (such as lower back, shoulder, or hip joint pain), and headaches.

ASH Participating Provider: One of the following types of providers:

- An acupuncturist who is licensed to provide acupuncture services in California and who has a contract with ASH Plans to provide Medically Necessary Acupuncture Services to you
- A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you

A list of ASH Participating Providers is available on the ASH Plans website at **ashlink.com/ash/kaisercamedicare** for Kaiser Permanente Senior Advantage Members, or **ashlink.com/ash/kp** for all other Members, or from the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**). The list of ASH Participating Providers is subject to change at any time, without notice. If you have questions, please call the ASH Plans Customer Service Department.

ASH Plans: American Specialty Health Plans of California, Inc., a California corporation.

Chiropractic Services: Chiropractic services include spinal and extremity manipulation and adjunctive therapies such as ultrasound, therapeutic exercise, or electrical muscle stimulation, when provided during the same course of treatment and in conjunction with chiropractic manipulative services, and other services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic supports and appliances) for the treatment of your Musculoskeletal and Related Disorder.

Emergency Acupuncture Services: Covered Acupuncture Services provided for the treatment of a Musculoskeletal and Related Disorder, nausea, or pain, which manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could expect the absence of immediate Acupuncture Services to result in serious jeopardy to your health or body functions or organs.

Emergency Chiropractic Services: Covered Chiropractic Services provided for the treatment of a Musculoskeletal and Related Disorder which manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could expect the absence of immediate Chiropractic Services to result in serious jeopardy to your health or body functions or organs.

Musculoskeletal and Related Disorders: Conditions with signs and symptoms related to the nervous,

muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions.

Non–Participating Provider: A provider other than an ASH Participating Provider.

Treatment Plan: One of the following, depending on whether the Treatment Plan is for Chiropractic Services or Acupuncture Services:

- The course of treatment for your Musculoskeletal and Related Disorder, which may include laboratory tests, X-rays, chiropractic supports and appliances, and a specific number of visits for chiropractic manipulations (adjustments) and adjunctive therapies that are Medically Necessary Chiropractic Services for you
- The course of treatment for your Musculoskeletal and Related Disorder, nausea, or pain, which will include a specific number of visits for acupuncture (including adjunctive therapies) that are Medically Necessary Acupuncture Services for you

Urgent Acupuncture Services: Acupuncture Services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy
- They cannot be delayed until you return to the Service Area

Urgent Chiropractic Services: Chiropractic Services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy
- They cannot be delayed until you return to the Service Area

ASH Participating Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

ASH Plans contracts with ASH Participating Providers and other licensed providers to provide the Services covered under this Amendment (including laboratory tests, X-rays, and chiropractic supports and appliances). You must receive Services covered under this Amendment from an ASH Participating Provider or another licensed provider with which ASH contracts to provide covered care, except for Services covered under "Emergency and Urgent Services Covered Under this Amendment" in the "Covered Services" section and Services that are not available from contracted providers and that are authorized in advance by ASH Plans.

How to Obtain Services

To obtain Services covered under this Amendment call an ASH Participating Provider to schedule an initial examination. If additional Services are required after the initial examination, verification that the Services are Medically Necessary may be required, as described under "Decision time frames" below. Your ASH Participating Provider will request any required medical necessity determinations. An ASH Plans clinician in the same or similar specialty as the provider of Services under review will determine whether the Services are or were Medically Necessary Services.

Decision time frames

The ASH Plans' clinician will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all of the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent Services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If ASH Plans needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your ASH Participating Provider will be informed in writing about the additional information, testing, or specialist that is needed, and the date that ASH Plans expects to make a decision.

Your ASH Participating Provider will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your ASH Participating Provider will be informed of the scope of the authorized Services. If ASH Plans does not authorize all of the Services, ASH Plans will send you a written decision and explanation, including the rationale for the decision and the criteria used to make the decision, within two business days after the decision is made. The letter will also include information about your appeal rights, which are

described in the "Coverage Decisions, Appeals, and Complaints" section of your Health Plan *EOC* for Kaiser Permanente Senior Advantage Members, and "Dispute Resolution" section of your Health Plan *EOC* for all other Members. Any written criteria that ASH Plans uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request. If you have questions or concerns, please contact ASH Plans or Kaiser Permanente as described under "Customer Service" in this Amendment.

Covered Services

We cover the Services listed in this "Covered Services" section, subject to exclusions described in the "Exclusions" section, only if all of the following conditions are satisfied:

- You are a Member on the date that you receive the Services
- ASH Plans has determined that the Services are Medically Necessary, except for:
  - the initial examination described under "Office Visits" in this "Covered Services" section
  - Services covered under "Emergency and Urgent Services Covered Under this Amendment" in this "Covered Services" section
- You receive the Services from ASH Participating Providers or other licensed providers with which ASH contracts to provide covered care, except for:
  - Services covered under "Emergency and Urgent Services Covered Under this Amendment" in this "Covered Services" section
  - Services that are not available from ASH Participating Providers or other licensed providers with which ASH contracts to provide covered care and that are authorized in advance by ASH Plans

When you receive covered Services, you must pay the Cost Share listed in this "Covered Services" section. If you receive Services that are not covered under this Amendment, you may be liable for the full price of those Services.

Note: If Charges for Services are less than the Copayment described in this "Covered Services" section, you will pay the lesser amount.

The Cost Share you pay for Services covered under this Amendment does not apply toward any Plan Deductible or Plan Out-of-Pocket Maximum described in your Health Plan *EOC*.

If you have questions about your Cost Share for specific Services that you are scheduled to receive or that your provider orders during a visit or procedure, please call the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**) weekdays from 5 a.m. to 6 p.m.

Coverage of Acupuncture Services under this Amendment is different from the coverage of acupuncture Services under your Health Plan *EOC*. You do not need a referral to get covered Services under this Amendment, but covered Services and your Cost Share may differ from those under your Health Plan *EOC*. If you receive acupuncture Services for which you have a referral (as described under "Getting a Referral" in the "How to Obtain Services" section of the *EOC*), then unless you tell us otherwise, we will assume that you are using your coverage under your Health Plan *EOC*.

If you are a Kaiser Permanente Senior Advantage Member, refer to your Health Plan *EOC* for information about the chiropractic Services that we cover in accord with Medicare guidelines, which are separate from the Services covered under this Amendment.

Office Visits

We cover up to a combined total of 20 of the following types of office visits per 12-month period at **a $15 Copayment per visit:**

- **Initial chiropractic examination:** An examination performed by an ASH Participating Provider to determine the nature of your problem (and, if appropriate, to prepare a Treatment Plan), and to provide Medically Necessary Chiropractic Services, which may include an adjustment and adjunctive therapy. We cover an initial examination only if you have not already received covered Chiropractic Services from an ASH Participating Provider in the same 12-month period for your Musculoskeletal and Related Disorder
- **Subsequent chiropractic office visits:** Subsequent ASH Participating Provider office visits for Chiropractic Services that are determined to be Medically Necessary by an ASH Plans clinician. These subsequent office visits may include an adjustment, adjunctive therapy, and a re-examination to assess the need to continue, extend, or change a Treatment Plan
- **Initial acupuncture examination:** An examination performed by an ASH Participating Provider to determine the nature of your problem (and, if appropriate, to prepare a Treatment Plan), and to provide Medically Necessary Acupuncture Services.

We cover an initial examination only if you have not already received covered Acupuncture Services from an ASH Participating Provider in the same 12-month period for your Musculoskeletal and Related Disorder, nausea, or pain

- **Subsequent acupuncture office visits:** Subsequent ASH Participating Provider office visits for Acupuncture Services that are determined to be Medically Necessary by an ASH Plans clinician, which may include a re-examination to assess the need to continue, extend, or change a Treatment Plan

Each office visit counts toward any visit limit, if applicable.

Laboratory Tests and X-rays

We cover Medically Necessary laboratory tests and X-rays when prescribed as part of covered chiropractic care described under "Office Visits" in this "Covered Services" section at **no charge** when an ASH Participating Provider provides the Services or refers you to another licensed provider with which ASH contracts to provide covered Services.

Chiropractic Supports and Appliances

We provide a **$50 Allowance per 12-month period** toward the ASH Plans fee schedule price for chiropractic appliances listed in this paragraph when the item is prescribed and provided to you by an ASH Participating Provider as part of covered chiropractic care described under "Office Visits" in this "Covered Services" section. If the price of the items in the ASH Plans fee schedule exceeds $50 (the Allowance), you will pay the amount in excess of $50 (and that payment does not apply toward the Plan Out-of-Pocket Maximum described in your Health Plan *EOC*). Covered chiropractic appliances are limited to: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports, and wrist braces.

Second Opinions

You may request a second opinion in regard to covered Services by contacting another ASH Participating Provider. Your visit to another ASH Participating Provider for a second opinion generally will count toward any visit limit, if applicable. An ASH Participating Provider may also request a second opinion in regard to covered Services by referring you to another ASH Participating Provider in the same or similar specialty. When you are referred by an ASH Participating Provider to another ASH Participating Provider for a second opinion, your visit to the other ASH Participating Provider will not count toward any visit limit, if applicable. An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial, and of your right to file a grievance as described under "Grievances" in this Amendment.

Emergency and Urgent Services Covered Under this Amendment

Emergency and urgent chiropractic Services

We cover Emergency Chiropractic Services and Urgent Chiropractic Services provided by an ASH Participating Provider or a Non–Participating Provider at **a $15 Copayment per visit**. We do not cover follow-up or continuing care from a Non-Participating Provider unless ASH Plans has authorized the Services in advance. Also, we do not cover Services from a Non-Participating Provider that ASH Plans determines are not Emergency Chiropractic Services or Urgent Chiropractic Services.

Emergency and urgent acupuncture Services

We cover Emergency Acupuncture Services and Urgent Acupuncture Services provided by an ASH Participating Provider or a Non–Participating Provider at **a $15 Copayment per visit**. We do not cover follow-up or continuing care from a Non–Participating Provider unless ASH Plans has authorized the Services in advance. Also, we do not cover Services from a Non-Participating Provider that ASH Plans determines are not Emergency Acupuncture Services or Urgent Acupuncture Services.

How to file a claim

As soon as possible after receiving Emergency Chiropractic Services or Urgent Chiropractic Services or Emergency Acupuncture Services or Urgent Acupuncture Services, you must file an ASH Plans claim form. To request a claim form or for more information, please call ASH Plans toll free at **1-800-678-9133** (TTY users call **711**) or visit the ASH Plans website at **ashlink.com**. You must send the completed claim form to:

ASH Plans
P.O. Box 509002
San Diego, CA 92150-9002

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage under this Amendment. (Note: Some items and services listed in this "Exclusions" section may be covered Services under your Health Plan *EOC*. Please refer to your Health Plan *EOC* for details.) These exclusions apply to all Services that would otherwise be covered under this Amendment regardless of whether the services are within the scope of a provider's license or certificate:

- Acupuncture services for conditions other than Musculoskeletal and Related Disorders, nausea, and pain
- Acupuncture performed with reusable needles
- Services provided by an acupuncturist that are not within the scope of licensure for an acupuncturist licensed in California
- For Acupuncture Services, adjunctive therapies unless provided during the same course of treatment and in conjunction with acupuncture
- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- For Chiropractic Services, adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered under "Chiropractic Supports and Appliances" in the "Covered Services" section of this Amendment
- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational Services. If coverage for a Service is denied because it is experimental or investigational and you want to appeal the denial, refer to your Health Plan *EOC* for information about the appeal process
- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other type of diagnostic imaging or radiology other than X-rays covered under the "Covered Services" section of this Amendment
- Ambulance and other transportation
- Education programs, non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California, except for Services covered under "Emergency and Urgent Services Covered Under this Amendment" in the "Covered Services" section
- Hospital services, anesthesia, manipulation under anesthesia, and related services
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Maintenance care (services provided to Members whose treatment records indicate that they have reached maximum therapeutic benefit)

Customer Service

If you have a question or concern regarding the Services you received from an ASH Participating Provider or any other licensed provider with which ASH contracts to provide covered Services, you may call the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**) weekdays from 5 a.m. to 6 p.m., or write ASH Plans at:

ASH Plans
Customer Service Department
P.O. Box 509002
San Diego, CA 92150-9002

Grievances

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about Services you received. If you are a Kaiser Permanente Senior Advantage Member, you may submit your grievance orally or in writing to Kaiser Permanente as described in the "Coverage Decisions, Appeals, and Complaints" section of your Health Plan *EOC.* Otherwise, you may submit your grievance orally or in writing to Kaiser Permanente as described in the "Dispute Resolution" section of your Health Plan *EOC*.

KAISER PERMANENTE® : TRADITIONAL PLAN

Coverage for: Individual/Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see https://kp.org/plandocuments or call 1-800-278-3296 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500 Individual / $3,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-800-278-3296 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 / visit	Not Covered	None
	Specialist visit	$10 / visit	Not Covered	None
	Preventive care/ screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRI's)	No Charge	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs (Tier 1)	Retail: $10 / prescription; Mail order: $20 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Preferred brand drugs (Tier 2)	Retail: $20 / prescription; Mail order: $40 / prescription	Not Covered	Up to a 30-day supply retail or 100-day supply mail order. Subject to formulary guidelines. No Charge for Contraceptives.
	Non-preferred brand drugs (Tier 2)	Retail: $20 / prescription; Mail order: $40 / prescription	Not Covered	The cost sharing for non-preferred brand drugs under this plan aligns with the cost sharing for preferred brand drugs (Tier 2), when approved through the formulary exception process.
	Specialty drugs (Tier 4)	20% coinsurance up to $250 / prescription	Not Covered	Up to a 30-day supply retail. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	Physician/surgeon fees are included in the Facility fee.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room care	$100 / visit	$100 / visit	None
	Emergency medical transportation	$50 / trip	$50 / trip	None
	Urgent care	$10 / visit	Not Covered	Non-Plan providers covered when temporarily outside the service area: $10 / visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	None
	Physician/surgeon fee	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 / individual visit. No Charge for other outpatient services	Not Covered	$5 / group visit.
	Inpatient services	No Charge	Not Covered	None
If you are pregnant	Office visits	No Charge	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	2-hour limit / visit, 3 visit limit / day, 100 visit limit / year.
	Rehabilitation services	Inpatient: No Charge; Outpatient: $10 / visit	Not Covered	None
	Habilitation services	$10 / visit	Not Covered	None
	Skilled nursing care	No Charge	Not Covered	100 day limit / benefit period.
	Durable medical equipment	20% coinsurance	Not Covered	Requires prior authorization.
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge for refractive exam	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental Care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (20 visit limit / year combined with chiropractic)
- Bariatric surgery
- Chiropractic care (20 visit limit / year combined with acupuncture)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-278-3296 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or www.healthhelp.ca.gov/

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711)
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-757-7585 (TTY: 711)
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296 (TTY: 711)

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$10**
- **Hospital (facility) copayment** **$0**
- **Other (blood work) copayment** **$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$60**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$10**
- **Hospital (facility) copayment** **$0**
- **Other (blood work) copayment** **$0**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$10**
- **Hospital (facility) copayment** **$0**
- **Other (x-ray) copayment** **$0**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$210**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Service Contact Center at 1-800-464-4000 (TTY 711), 24 hours a day, 7 days a week (except closed holidays). If you cannot hear or speak well, please call 711.

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, or another format, call our Member Service Contact Center and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with Kaiser Permanente if you believe we have failed to provide these services or unlawfully discriminated in another way. Please refer to your Evidence of Coverage or Certificate of Insurance for details. You may also speak with a Member Services representative about the options that apply to you. Please call Member Services if you need help filing a grievance.

You may submit a discrimination grievance in the following ways:

- By phone: Call member services at 1-800-464-4000 (TTY 711) 24 hours a day, 7 days a week (except closed holidays)
- By mail: Call us at 1-800-464-4000 (TTY 711) and ask to have a form sent to you
- In person: Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)
- Online: Use the online form on our website at kp.org

You may also contact the Kaiser Permanente Civil Rights Coordinators directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office of Civil Rights (For Medi-Cal Beneficiaries Only)

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email.

- By phone: Call DHCS Office of Civil Rights at 916-440-7370 (TTY 711)
- By mail: Fill out a complaint form or send a letter to:
  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- Online: Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- By phone: Call 1-800-368-1019 (TTY 711 or 1-800-537-7697)
- By mail: Fill out a complaint form or send a letter to:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at:
  http://www.hhs.gov/ocr/office/file/index.html
- Online: Visit the Office of Civil Rights Complaint Portal at:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Aviso de no discriminación

La discriminación es ilegal. Kaiser Permanente cumple con las leyes de los derechos civiles federales y estatales.

Kaiser Permanente no discrimina ilícitamente, excluye ni trata a ninguna persona de forma distinta por motivos de edad, raza, identificación de grupo étnico, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, género, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, condición médica, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

Kaiser Permanente ofrece los siguientes servicios:

- Ayuda y servicios sin costo a personas con discapacidades para que puedan comunicarse mejor con nosotros, como lo siguiente:
    - intérpretes calificados de lenguaje de señas,
    - información escrita en otros formatos (braille, impresión en letra grande, audio, formatos electrónicos accesibles y otros formatos).
- Servicios de idiomas sin costo a las personas cuya lengua materna no es el inglés, como:
    - intérpretes calificados,
    - información escrita en otros idiomas.

Si necesita nuestros servicios, llame a nuestra Central de Llamadas de Servicio a los Miembros al 1-800-464-4000 (TTY 711) las 24 horas del día, los 7 días de la semana (excepto los días festivos). Si tiene deficiencias auditivas o del habla, llame al 711.

Este documento estará disponible en braille, letra grande, casete de audio o en formato electrónico a solicitud. Para obtener una copia en uno de estos formatos alternativos o en otro formato, llame a nuestra Central de Llamadas de Servicio a los Miembros y solicite el formato que necesita.

Cómo presentar una queja ante Kaiser Permanente

Usted puede presentar una queja por discriminación ante Kaiser Permanente si siente que no le hemos ofrecido estos servicios o lo hemos discriminado ilícitamente de otra forma. Consulte su Evidencia de Cobertura (Evidence of Coverage, EOC) o certificado de seguro para obtener más información. También puede hablar con un representante de Servicio a los Miembros sobre las opciones que se apliquen a su caso. Llame a Servicio a los Miembros si necesita ayuda para presentar una queja.

Puede presentar una queja por discriminación de las siguientes maneras:

- Por teléfono: llame a Servicio a los Miembros al 1 800-464-4000 (TTY 711), las 24 horas del día, los 7 días de la semana (excepto los días festivos).
- Por correo postal: llámenos al 1 800-464-4000 (TTY 711) y pida que se le envíe un formulario.
- En persona: llene un formulario de Queja o reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte su directorio de proveedores en kp.org/facilities [cambie el idioma a español] para obtener las direcciones).
- En línea: utilice el formulario en línea en nuestro sitio web en kp.org/espanol.

También puede comunicarse directamente con el coordinador de derechos civiles (Civil Rights Coordinator) de Kaiser Permanente a la siguiente dirección:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

Cómo presentar una queja ante la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica de California (Solo para beneficiarios de Medi-Cal)

También puede presentar una queja sobre derechos civiles ante la Oficina de Derechos Civiles (Office of Civil Rights) del Departamento de Servicios de Atención Médica de California (California Department of Health Care Services) por escrito, por teléfono o por correo electrónico:

- Por teléfono: llame a la Oficina de Derechos Civiles del Departamento de Servicios de Atención Médica (Department of Health Care Services, DHCS) al 916-440-7370 (TTY 711).
- Por correo postal: llene un formulario de queja o envíe una carta a:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Los formularios de queja están disponibles en: http://www.dhcs.ca.gov/Pages/Language_Access.aspx (en inglés).
- En línea: envíe un correo electrónico a CivilRights@dhcs.ca.gov.

Cómo presentar una queja ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU.

Puede presentar una queja por discriminación ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de EE. UU. (U.S. Department of Health and Human Services). Puede presentar su queja por escrito, por teléfono o en línea:

- Por teléfono: llame al 1-800-368-1019 (TTY 711 o al 1-800-537-7697).
- Por correo postal: llene un formulario de queja o envíe una carta a:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Los formularios de quejas están disponibles en http://www.hhs.gov/ocr/office/file/index.html (en inglés).
- En línea: visite el Portal de quejas de la Oficina de Derechos Civiles en: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf (en inglés).

反歧視聲明

歧視是違反法律的行為。Kaiser Permanente 遵守州政府與聯邦政府的民權法。

Kaiser Permanente 不因年齡、人種、族群認同、膚色、原國籍、文化背景、祖籍、宗教、生理性別、社會性別、性認同、性表現、性取向、婚姻狀況、身體或精神殘障、病況、付款來源、遺傳資訊、公民身份、母語或移民身份而非法歧視、排斥或差別對待任何人。

Kaiser Permanente 提供下列服務：

- 為殘障人士提供免費協助與服務以幫助其更好地與我們溝通，例如：
  - 合格手語翻譯員
  - 其他格式的書面資訊（盲文版、大字版、語音版、通用電子格式及其他格式）
- 為母語非英語的人士提供免費語言服務，例如：
  - 合格口譯員
  - 其他語言的書面資訊

如果您需要上述服務，請打電話 1-800-464-4000 (TTY 711) 給會員服務聯絡中心，每週 7 天，每天 24 小時（節假日除外）。如果您有聽力或語言困難，請打電話 711。

若您提出要求，我們可為您提供本文件的盲文版、大字版、錄音卡帶或電子格式。如要得到上述一種替代格式或其他格式的版本，請打電話給會員服務聯絡中心並索取您需要的格式。

如何向 Kaiser Permanente 投訴

如果您認為我們未能提供上述服務或有其他形式的非法歧視行為，您可向 Kaiser Permanente 提出歧視投訴。請參閱您的《承保範圍說明書》*(Evidence of Coverage)* 或《保險證明》*(Certificate of Insurance)* 瞭解詳情。您也可以向會員服務部代表諮詢適用於您的選項。如果您在投訴時需要協助，請打電話給會員服務部。

您可透過下列方式投訴歧視：

- **電話：** 打電話 1 800-464-4000 (TTY 711) 聯絡會員服務部，每週 7 天，每天 24 小時（節假日除外）
- **郵寄：** 打電話 1 800-464-4000 (TTY 711) 與我們聯絡，要求將投訴表寄給您
- **親自提出：** 在保險計劃下屬設施的會員服務辦公室填寫投訴或索賠／申請表（請在 kp.org/facilities 網站的保健業者名錄上查詢地址）
- **線上：** 使用 kp.org 網站上的線上表格

您也可直接與 Kaiser Permanente 民權事務協調員聯絡，地址如下：

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

如何向加州保健服務部民權辦公室投訴（僅限 *Medi-Cal* 受益人）

您也可透過書面方式、電話或電子郵件向加州保健服務部民權辦公室提出民權投訴：

- **電話：**打電話 916-440-7370 (TTY 711) 聯絡保健服務部 (DHCS) 民權辦公室

- **郵寄：**填寫投訴表或寄信至：

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413
  您可在網站上 http://www.dhcs.ca.gov/Pages/Language_Access.aspx 取得投訴表

- **線上：**發送電子郵件至 CivilRights@dhcs.ca.gov

如何向美國健康與民眾服務部民權辦公室投訴

您可向美國健康與民眾服務部民權辦公室提出歧視投訴。您可透過書面、電話或線上提出投訴：

- **電話：**打電話 1-800-368-1019（TTY 711 或 1-800-537-7697）

- **郵寄：**填寫投訴表或寄信至：

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  您可在網站上取得投訴表：
  http:www.hhs.gov/ocr/office/file/index.html 取得投訴表
- **郵寄：**訪問民權辦公室投訴入口網站：
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf。

Thông Báo Không Phân Biệt Đối Xử

Phân biệt đối xử là trái với pháp luật. Kaiser Permanente tuân thủ các luật dân quyền của Tiểu Bang và Liên Bang.

Kaiser Permanente không phân biệt đối xử trái pháp luật, loại trừ hay đối xử khác biệt với người nào đó vì lý do tuổi tác, chủng tộc, màu da, nguồn gốc quốc gia, tôn giáo, niềm tin, giới tính, xu hướng tình dục, bản dạng giới, tình trạng hôn nhân, thông tin di truyền, quyền công dân, ngôn ngữ mẹ đẻ hoặc tình trạng nhập cư.

Kaiser Permanente cung cấp các dịch vụ sau:

- Phương tiện hỗ trợ và dịch vụ miễn phí cho người khuyết tật để giúp họ giao tiếp hiệu quả hơn với chúng tôi, chẳng hạn như:
  - Thông dịch viên ngôn ngữ ký hiệu đủ trình độ
  - Thông tin bằng văn bản theo các định dạng khác (chữ nổi braille, bản in khổ chữ lớn, âm thanh, định dạng điện tử dễ truy cập và các định dạng khác)
- Dịch vụ ngôn ngữ miễn phí cho những người có ngôn ngữ chính không phải là tiếng Anh, chẳng hạn như:
  - Thông dịch viên đủ trình độ
  - Thông tin được trình bày bằng các ngôn ngữ khác

Nếu quý vị cần những dịch vụ này, xin gọi đến Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi theo số 1-800-464-4000 (TTY 711), 24 giờ trong ngày, 7 ngày trong tuần (đóng cửa ngày lễ). Nếu quý vị không thể nói hay nghe rõ, vui lòng gọi 711.

Theo yêu cầu, tài liệu này có thể được cung cấp cho quý vị dưới dạng chữ nổi braille, bản in khổ chữ lớn, băng thu âm hay dạng điện tử. Để lấy một bản sao trong một trong những định dạng thay thế này hay định dạng khác, xin gọi đến Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi và yêu cầu định dạng mà quý vị cần.

Cách đệ trình phàn nàn với Kaiser Permanente

Quý vị có thể đệ trình phàn nàn về phân biệt đối xử với Kaiser Permanente nếu quý vị tin rằng chúng tôi đã không cung cấp những dịch vụ hay áp dụng phân biệt đối xử bất hợp pháp theo cách khác với bảo hiểm y tế Kaiser Permanente hay Chương Trình Bảo Hiểm Chăm Sóc Sức Khỏe của quý vị. Để biết thêm thông tin về những lựa chọn áp dụng cho quý vị, vui lòng gọi đến ban Dịch Vụ Hội Viên hoặc có thể trực tuyến với Cơ Sở Thuộc Chương Trình (truy cập danh mục nhà cung cấp của quý vị tại kp.org/facilities để biết địa chỉ) Hội Viên nếu quý vị cần được trợ giúp để đệ trình phàn nàn.

Quý vị có thể đệ trình phàn nàn về phân biệt đối xử bằng các cách sau đây:

- Qua điện thoại: Gọi đến ban Dịch Vụ Hội Viên theo số 1-800-464-4000 (TTY 711) 24 giờ trong ngày, 7 ngày trong tuần (đóng cửa ngày lễ)
- Qua thư tín: Gọi chúng tôi theo số 1-800-464-4000 (TTY 711) và yêu cầu gửi mẫu đơn cho quý vị
- Trực tiếp: Hoàn tất mẫu đơn Than Phiền hay Yêu Cầu Thanh Toán/Yêu Cầu Quyền Lợi tại văn phòng dịch vụ hội viên ở một
- Trực tuyến: Sử dụng mẫu đơn trực tuyến trên trang mạng của chúng tôi tại kp.org

Quý vị cũng có thể liên hệ trực tiếp với Điều Phối Viên Dân Quyền của Kaiser Permanente theo địa chỉ dưới đây:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

Cách đệ trình phàn nàn với Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế California (Dành Riêng Cho Người Thụ Hưởng Medi-Cal)

Quý vị cũng có thể đệ trình than phiền về dân quyền với Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế California bằng văn bản, qua điện thoại hay qua email:

- Qua điện thoại: Gọi đến Văn Phòng Dân Quyền Ban Dịch Vụ Y Tế (Department of Health Care Services, DHCS) theo số 916-440-7370 (TTY 711)
- Qua thư tín: Điền mẫu đơn than phiền và hay gửi thư đến:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Mẫu đơn than phiền hiện có tại: http://www.dhcs.ca.gov/Pages/Language_Access.aspx

- Trực tuyến: Gửi email đến CivilRights@dhcs.ca.gov

Cách đệ trình phàn nàn với Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ.

Quý vị cũng có quyền đệ trình than phiền về phân biệt đối xử với Văn Phòng Dân Quyền của Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ. Quý vị có thể đệ trình than phiền bằng văn bản, qua điện thoại hoặc trực tuyến:

- Qua điện thoại: Gọi 1-800-368-1019 (TTY 711 hay 1-800-537-7697)
- Qua thư tín: Điền mẫu đơn than phiền và hay gửi thư đến:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Mẫu đơn than phiền hiện có tại:
  http://www.hhs.gov/ocr/office/file/index.html

- Trực tuyến: Truy cập Cổng Thông Tin Than Phiền của Văn Phòng Dân Quyền tại: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

NOTICE OF LANGUAGE ASSISTANCE

English: This is important information from Kaiser Permanente. If you need help understanding this information, please call **1-800-464-4000 (TTY 711)** and ask for language assistance. Help is available 24 hours a day, 7 days a week, excluding holidays. We can also help you with auxiliary aids and alternative formats.

Arabic: تحتوي هذه الوثيقة على معلومات مهمة من Kaiser Permanente.إذا كنت بحاجة للمساعدة في فهم هذه المعلومات، يرجى الاتصال على الرقم **(TTY: 711) 1-800-464-4000**وطلب مساعدة لغوية. المساعدة متوفرة على مدار الساعة طيلة أيام الأسبوع، باستثناء أيام العطلات الرسمية. يمكننا أيضاً تزويدك بمساعدات إضافية وتنسيقات بديلة.

Armenian: Սա կարևոր տեղեկություն է «Kaiser Permanente»-ից: Եթե այս տեղեկությունը հասկանալու համար Ձեզ օգնություն է հարկավոր, խնդրում ենք զանգահարել **1-800-464-4000 (TTY 711)** հեռախոսահամարով և օժանդակություն ստանալ լեզվի հարցում: Զանգահարեք օրը 24 ժամ, շաբաթը 7 օր՝ բացի տոն օրերից: Մենք նաև կարող ենք օգնել Ձեզ օժանդակ օգնության և այլընտրանքային ձևաչափերի հարցում:

Chinese: 這是來自 Kaiser Permanente 的重要資訊。如果您需要協助瞭解此資訊，請致電 **1-800-757-7585 (TTY 專線 711)** 尋求語言協助。我們每週 7 天，每天 24 小時皆提供協助（節假日休息）。我們還可以幫助您獲取輔助設備和其它格式。

Farsi: این اطلاعات مهمی از سوی Kaiser Permanente می باشد. اگر در فهمیدن این اطلاعات به کمک نیاز دارید، لطفاً با شماره **1-800-464-4000 (TTY 711)** تماس گرفته و برای امداد زبانی درخواست کنید. کمک و راهنمایی در 24 ساعت شبانروز و 7 روز هفته، شامل روزهای تعطیل موجود است. ما همچنین می توانیم برای شما کمکهای جانبی و به صورتهای دیگر را فراهم کنیم.

Hindi: यह Kaiser Permanente की ओर से महत्वपूर्ण सूचना है। यदि आपको इस सूचना को समझने के लिए मिि की जरूरत है, तो कृपया **1-800-464-4000 (TTY 711)** पर फोन करें और भाषा सहायता के लिए पूछें। सहायता छुट्टियों को छोड़कर, सप्ताह के सातों दिन, दिन के 24 घंटे, उपिब्ध है। हम सहायक साधनों और वैकल्पपक प्रारूपों को प्राप्त करने में भी आपकी मिि कर सकते हैं।

Hmong: Qhov xov xwm no tseem ceeb los ntawm Kaiser Permanente. Yog koj xav tau kev pab kom nkag siab cov xov xwm no, thov hu rau **1-800-464-4000 (TTY 711)** thiab thov kev pab txhais lus. Muaj kev pab 24 teev ib hnub twg, 7 hnub ib lim tiam twg, tsis xam cov hnub caiv. Peb kuj muab tau lwm yam kev pab rau koj thiab ua lwm yam ntaub ntawv.

Japanese: Kaiser Permanente から重要なお知らせがあります。この情報を理解するためにヘルプが必要な場合は、**1-800-464-4000 (TTY 回線 711)** に電話して、言語サービスを依頼してください。このサービスは年中無休（祝祭日を除く）でご利用いただけます。補助器具・サービスや別のフォーマットについてもご相談いただけます。

Khmer:នេះគឺជាព័ត៌មាេសំខាេ់ មកពី Kaiser Permanente។ នបសសន្ទេកករតវការជំេយយ ឲយបាេយល់ដឹងព័ត៌មាេនេះ សូមទូជស័ព្ទនៅនលខ **1-800-464-4000 (TTY 711)** េនងនសកសសំេយយខាងសា។។ េយយគឺមាេ 24 នមា៉ងមយៃថ្ងៃ 7 ៃងៃមយយអាទនតយ ជយមទាំង្ងៃបំណយផង។ នយសងកអាអាជំយឃ្ជកកជាមយយេឹងបបកជណជំេយយទំនាក់ទំេងសរមាប៉ុកកពនរជេនងជាទរមង់េយសនផេង១។

Korean: 본 정보는 Kaiser Permanente 에서 전하는 중요한 메시지입니다. 본 정보를 이해하는 데 도움이 필요하시면, **1-800-464-4000 (TTY 711)** 번으로 전화해 언어 지원 서비스를 요청하십시오. 요일 및 시간에 관계없이 언제든지 도움을 제공해 드립니다(공휴일 제외). 또한 보조기구 및 대체 형식의 자료를 지원해 드릴 수 있습니다.

Laotian: ນີ້ແມ່ນຂໍ້ມູນສຳຄັນຈາກ Kaiser Permanente. ຖ້າວ່າ ທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການຊ່ວຍໃຫ້ເຂົ້າໃຈຂໍ້ມູນນີ້, ກະລຸນາໂທຣ **1-800-464-4000 (TTY 711)** ແລະຂໍເອົາການຊ່ວຍເຫຼືອດ້ານພາສາ. ການຊ່ວຍເຫຼືອມໃຫ້ຕະຫຼອດ 24 ຊ່ວໂມງ, 7 ວນຕ່ ້ອາທິດ, ບ ່ ວ່ ນວນພກຕ່ ່ າງໆ. ພວກເຮົ ່ ຍງສ ່ ຳ ່ ດຊ ່ ວຍທ ່ ່ ານໃນ ດ ່ ຳ ນອ ່ ປະກອນຊ ່ ວຍເສ ່ ີ ມ ແລະ ຮ ູ ບແບບທ ່ ່ າງເລ ື ອກອ ່ ື ນໄດ.ໍ

Mien: Naaiv se benx jienv sic dauh waac-fienx yiem naaiv Kaiser Permanente bun daaih. Beiv taux meih qiemx longc mienh tengx doqc naaiv deix waac-fienx liouh porv bun bieqc hnyouv nor, daaix luic douc waac daaih lorx **1-800-464-4000 (TTY 711)** aengx caux tov heuc tengx nzie faan waac bun muangx. Mbenc nzoih liouh tengx yiem yietc hnoi benx 24 norm ziangh hoc, yietc norm liv baaiz mbenc maaih 7 hnoi, simv cuotv hnoi-gec oc. Yie mbuo corc haih mbenc wuotc ginc jaa-dorngx tengx nzie goux aengx caux liouh bun ginv longc sou-guv daan puix horpc meih.

Navajo: Díí éí hane’ bíhólníihii át’éego Kaiser Permanente yee nihalne’. Díí hane’ígíí doo hazhó’ó bik’i’diitįįhgóó t’áá shǫǫdí koji’ hodíílnih **1-800-464-4000 (TTY 711)** áko saad bee áká i’iilyeed yídíikił. Kwe’é áká aná’álwo’ t’áá áłahjį’ naadiindįį’ ahéé’ílkidgóó dóó tsosts’id jį ąą’át’é. Dahodílzingóne’ éí dá’deelkaal. Áádóó hane’ bee bik’i’ di’díítíiłígíí dóó t’áá łahgo át’éego hane’ nich’į ádoolníił.

Punjabi: ਇਹ Kaiser Permanente ਵਲੋਂ ਜ਼ਰੂਰੀ ਜਾਣਕਾਰੀ ਹੈ। ਜੇ ਤੁਹਾਨੰ ੂ ਇਸ ਜਾਣਕਾਰੀ ਨੰ ੂ ਸਮਝਣ ਲਈ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਕਕਰਪਾ ਕਰਕੇ **1-800-464-4000 (TTY 711)** 'ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਲਈ ਪੁਛੋ। ਮਦਦ, ਛੁਟੀਆਂ ਨੰ ੂ ਛੱਡ ਕੇ, ਹਫ਼ਤੇ ਦੇ 7 ਕਦਨ, ਅਤੇ ਕਦਨ ਦੇ 24 ਘੰਟੇ ਮੌਜੂਦ ਹੈ। ਅਸੀਂ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਕਵਕਲਕਪਕ ਫਾਰਮੈਟਾਂ ਕਵੱਚ ਵੀ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦੇ ਹਾਂ।

Russian: Это важная информация от Kaiser Permanente. Если Вам требуется помощь, чтобы понять эту информацию, позвоните по номеру **1-800-464-4000 (линия TTY 711)** и попросите предоставить Вам услуги переводчика. Помощь доступна 24 часа в сутки, 7 дней в неделю, кроме праздничных дней. Мы также можем помочь вам с вспомогательными средствами и альтернативными форматами.

Spanish: La presente incluye información importante de Kaiser Permanente. Si necesita ayuda para entender esta información, llame al **1-800-788-0616 (TTY 711)** y pida ayuda linguística. Hay ayuda disponible 24 horas al día, siete días a la semana, excluidos los días festivos. También podemos ayudarle con recursos para discapacidades y formatos alternativos.

Tagalog: Ito ay importanteng impormasyon mula sa Kaiser Permanente. Kung kailangan ninyo ng tulong para maunawan ang impormasyong ito, mangyaring tumawag sa **1-800-464-4000 (TTY 711)** at humingi ng tulong kaugnay sa lengguwahe. May makukuhang tulong 24 na oras bawat araw, 7 araw bawat linggo, maliban sa mga araw na pista opisyal. Matutulungan din namin kayo sa mga pantulong na gamit o serbisyo at mga alternatibong format.

Thai: นี่เป็นขอมูลสำคัญจาก Kaiser Permanente หากคุณตองการความช่วยเหลือในการทำความเขาใจขอมูลนี้ โปรด โทร **1-800-464-4000 (โหมด TTY 711)** และขอความช่วยเหลือดานภาษา เราพรอมใหความช่วยเหลือตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์ ยกเวนวันหยุดราชการ เรายังสามารถจัดหาอุปกรณ์และวัสดุช่วยเหลือในรูปแบบอื่นไดอ ีกดวย

Ukranian: У цьому повідомленні міститься важлива інформація від Kaiser Permanente. Якщо надана інформація не зрозуміла й вам потрібна допомога, зателефонуйте за номером **1-800-464-4000 (TTY 711)** і попросіть надати вам послугу перекладача. Наші співробітники надають допомогу цілодобово, 7 днів на тиждень, за винятком святкових днів. Також ми можемо допомогти вам, надавши допоміжні засоби й матеріали в альтернативних форматах.

Vietnamese: Đây là thông tin quan trọng từ Kaiser Permanente. Nếu quý vị cần được giúp đỡ để hiểu rõ thông tin này, vui lòng gọi số **1-800-464-4000 (TTY 711)** và yêu cầu được cấp dịch vụ về ngôn ngữ. Quý vị sẽ được giúp đỡ 24 giờ trong ngày, 7 ngày trong tuần, trừ ngày lễ. Chúng tôi cũng có thể giúp quý vị với các phương tiện trợ giúp bổ trợ và hình thức thay thế.

Disclosure Form Part One

606405 Latitude AI LLC dba Latitude AI
Home Region: Northern California
1/1/24 through 12/31/24

Principal benefits for Kaiser Permanente Traditional HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$10 per visit
Most Physician Specialist Visits	$10 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$10 per visit
Most physical, occupational, and speech therapy	$10 per visit

Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge
Physician Specialist Visits by interactive video	No charge
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge
Physician Specialist Visits by telephone	No charge

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge

Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge

Emergency Services	**You Pay**
Emergency department visits	$100 per visit

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see “Hospital Inpatient Services” for inpatient Cost Share)

Ambulance Services	**You Pay**
Ambulance Services	$50 per trip

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	$10 for up to a 30-day supply
Most generic (Tier 1) refills through our mail-order service	$20 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy	$20 for up to a 30-day supply
Most brand-name (Tier 2) refills through our mail-order service	$40 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	20% Coinsurance (not to exceed $250) for up to a 30-day supply

Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	20% Coinsurance

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge

(continues)

Mental Health Services	**You Pay**
Individual outpatient mental health evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	$10 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Services to diagnose or treat infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	the Cost Share you would pay if the Services were to treat any other condition
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Disclosure Form Part Two

Kaiser Foundation Health Plan, Inc.
Northern and Southern California Regions

Overview of your coverage

Kaiser Permanente Traditional HMO Plan
Kaiser Permanente Deductible HMO Plan
Kaiser Permanente HSA-Qualified High Deductible Health Plan (HDHP) HMO Plan

Introduction

This *Disclosure Form Part Two* provides an overview of some of the important features of your Kaiser Permanente membership. Please refer to *Disclosure Form Part One* for a summary of the most frequently asked-about benefits.

These documents are only a summary of your Health Plan coverage. For details about the terms and conditions of coverage, refer to the *Evidence of Coverage ("EOC").* You have the right to review the *EOC* before enrolling. To obtain a copy, please contact your group.

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY OBTAIN HEALTH CARE. If you have special health care needs, carefully read the sections that apply to you.

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Service Areas in California (the Northern California or Southern California Region), which we call your "Home Region." Refer to *Your Benefits (Disclosure Form Part One)* to learn which California Region is your Home Region. This *Disclosure Form* describes your coverage in your Home Region.

The Services described under *Your Benefits (Disclosure Form Part One)* are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside your Home Region, except where specifically noted to the contrary in the *EOC* for authorized referrals, covered Services received outside of your Home Region Service Area, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Also, this *Disclosure Form* describes different benefit plans, for example benefit plans that may include deductibles for specified Services. Everything in this section of the *Disclosure Form* applies to all benefit plans, except as otherwise indicated.

Please see *Your Benefits (Disclosure Form Part One)* for a summary of deductibles, Copayments, and Coinsurance. If you have questions about benefits, please call Member Services at **1-800-464-4000** (TTY users call **711**) or refer to the *EOC*.

Some capitalized terms have special meaning in this *Disclosure Form,* as described in the "Definitions" section at the end of this booklet.

Note: State law requires disclosure form documents to include the following notice: "**Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Kaiser Permanente Member Services at 1-800-464-4000 (TTY users call 711), to ensure that you can obtain the health care services that you need."**

Please be aware that if a Service is covered but not available at a particular Plan Facility, we will make it available to you at another facility.

How to Obtain Services

Our Members receive covered medical care from Plan Providers (physicians, registered nurses, nurse practitioners, and other medical professionals) inside your Home Region Service Area at Plan Facilities except as described in this *Disclosure Form* or the *EOC* for the following Services listed below:

- Authorized referrals
- Emergency ambulance Services
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care
- Hospice care
- Covered Services received outside of your Home Region Service Area

For Plan Facility locations, refer to the facility listing on our website at **kp.org/facilities**, or call Member Services at **1-800-464-4000** (TTY users call **711**).

Emergency Services

Emergency Care
If you have an Emergency Medical Condition, call **911** (where available) or go to the nearest emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non-Plan Providers anywhere in the world.

Emergency Services are available from Plan Hospital emergency departments 24 hours a day, seven days a week.

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered Emergency Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement.

Post-Stabilization Care
We cover Post-Stabilization Care from a Non–Plan Provider in the following circumstances (refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section of your *EOC* for details):

- When you receive Post-Stabilization Care from a Non-Plan Provider inside of California, or from a Cigna PPO Network facility outside of a Kaiser Permanente State, we cover the Services only if prior authorization for the care is obtained or if otherwise required by applicable law (prior authorization means that the Services must be approved in advance).
- Post-Stabilization Care from all other providers outside of California if it qualifies as Emergency Services under federal law (your treating physician has determined that you are not able to travel to a Plan Provider taking into account your medical condition or you or your authorized representative are not in a condition to be able to provide consent in accord with state informed consent law).

You are responsible for the full cost of Services from a Non-Plan Provider after your condition has been Stabilized in the following circumstances:

- If you receive Post-Stabilization Care that has not been authorized from a Non–Plan Provider inside California or a Cigna PPO Network facility outside of a Kaiser Permanente State
- If you receive Post-Stabilization Care that doesn't qualify as Emergency Services from any other provider outside of California that has not been authorized (in such circumstances, the Non-Plan Provider may provide notice and seek your consent to provide the Services, but these Service are not covered unless we have authorized them)

Urgent Care

Inside your Home Region Service Area
If you think you may need Urgent Care, call the appropriate appointment or advice nurse telephone number at a Plan Facility.

Out-of-Area Urgent Care
If you need Urgent Care due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), we cover Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health from a Non–Plan Provider if all of the following are true:

- You receive the Services from Non–Plan Providers while you are temporarily outside your Home Region Service Area
- You reasonably believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to your Home Region Service Area

You do not need prior authorization for Out-of-Area Urgent Care.

To obtain follow-up care from a Plan Provider, call the appointment or advice telephone number at a Plan Facility. We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care, except for covered durable medical equipment. If you require durable medical equipment related to your Urgent Care after receiving Out-of-Area Urgent Care, your provider must obtain prior authorization.

Your ID card

Each Member's Kaiser Permanente ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. When you get care, please bring your ID card and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call Member Services if we ever inadvertently issue you more than one medical record number or if you need to replace your ID card.

If you need to get care before you receive your ID card, please ask your group for your group (purchaser) number and the date your coverage became effective.

Plan Facilities and Your Guidebook to Kaiser Permanente Services (*Your Guidebook*)

At most of our Plan Facilities, you can usually receive all the covered Services you need, including Emergency Services, Urgent Care, specialty care, pharmacy, and laboratory tests. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you. For a listing of facility locations in your area, please visit our website at **kp.org/facilities** or call Member Services at **1-800-464-4000** (TTY users call **711)**.

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available at Plan Hospital emergency departments listed in *Your Guidebook* (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for emergency department locations in your area)
- Same-day Urgent Care appointments are available at many locations (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for Urgent Care locations in your area)
- Many Plan Medical Offices have evening and weekend appointments

- Many Plan Facilities have a Member Services office (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for locations in your area)

Plan Medical Offices and Plan Hospitals for your area are listed in detail in *Your Guidebook to Kaiser Permanente Services* (*Your Guidebook*) and on our website at **kp.org**. *Your Guidebook* describes the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. *Your Guidebook* also explains how to use our Services and make appointments, lists hours of operations, and includes a detailed telephone directory for appointments and advice. *Your Guidebook* provides other important information, such as preventive care guidelines and your Member rights and responsibilities. *Your Guidebook* is subject to change and is periodically updated. You can get a copy by visiting our website at **kp.org** or by calling Member Services at **1-800-464-4000** (TTY users call **711**), 24 hours a day, seven days a week (except closed holidays).

Your personal Plan Physician

Personal Plan Physicians play an important role in coordinating care, including hospital stays and referrals to specialists. We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology who the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. You can change your personal Plan Physician at any time for any reason. To learn how to select a personal Plan Physician, please call Member Services at **1-800-464-4000** (TTY users call **711**). You can find a directory of our Plan Physicians on our website at **kp.org**.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and physical, occupational, and speech therapies. Also, a Plan Physician must refer you before you can get care from Qualified Autism Service Providers covered under "Behavioral Health Treatment for Autism Spectrum Disorder" in the *EOC***.** However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- The provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the specialist is prescribed. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

The following are examples of Services require prior authorization by the Medical Group for the Services to be covered (prior authorization means that the Medical Group must approve the Services in advance):

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management ("UM") is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at **kp.org/UM** or call Member Services to request a printed copy. Refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section of your *EOC* for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals. This description is only a brief summary of the authorization procedure. For more information, refer to the *EOC* or call Member Services at **1-800-464-4000** (TTY users call **711**).

Second Opinions

You have the right to a second opinion. If you want a second opinion, you can ask Member Services to help you arrange one with another Plan Physician who is an appropriately qualified medical professional for your condition. For more information, refer to the *EOC*.

Timely Access to Care

Standards for appointment availability

The California Department of Managed Health Care ("DMHC") developed the following standards for appointment availability. This information can help you know what to expect when you request an appointment.

- Urgent care appointment: within 48 hours
- Routine (non-urgent) primary care appointment (including adult/internal medicine, pediatrics, and family medicine): within 10 business days
- Routine (non-urgent) specialty care appointment with a physician: within 15 business days
- Routine (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician: within 10 business days

- Follow-up (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician, for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition: within 10 business days

The standards for appointment availability do not apply to Preventive Services. Your Plan Provider may recommend a specific schedule for Preventive Services, depending on your needs. Except as specified above for mental health care and substance use disorder treatment, the standards also do not apply to periodic follow-up care for ongoing conditions or standing referrals to specialists.

Timely access to telephone assistance

- DMHC developed the following standards for answering telephone questions:
- For telephone advice about whether you need to get care and where to get care: within 30 minutes, 24 hours a day, seven days a week.
- For general questions: within 10 minutes during normal business hours.

Interpreter Services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information about the interpreter services we offer, please call Member Services.

How Plan Providers are Paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital care for Members, please visit our website at **kp.org** or call Member Services at **1-800-464-4000** (TTY users call **711**).

Your Costs

Cost Share (deductibles, Copayments, and Coinsurance)

When you receive covered Services, you must pay the Cost Share amount listed in the *EOC*. In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. Keep in mind that this payment may cover only a portion of your total Cost Share for the covered Services you receive, and you will be billed for any additional amounts that are due. In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for any Cost Share amounts that are due. The following are examples of when you may get a bill:

- You receive non-preventive Services during a preventive visit
- You receive diagnostic Services during a treatment visit
- You receive treatment Services during a diagnostic visit
- You receive Services from a second provider during your visit
- A Plan Provider is not able to collect Cost Share at the time you receive Services

In some cases, a Non-Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

If you have questions about the Cost Share for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at **kp.org/memberestimates** to use our cost estimate tool or call Member Services.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call weekdays 7 a.m. to 7 p.m. at **1-800-390-3507** (TTY users call **711**). Refer to *Your Benefits (Disclosure Form Part One)* to find out if you have a Plan Deductible
- For all other Cost Share estimates, please call **1-800-464-4000** (TTY users call **711**) 24 hours a day, seven days a week (except closed holidays)

Cost Share estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services. Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Copayments and Coinsurance

A summary of Copayments and Coinsurance is listed in *Your Benefits (Disclosure Form Part One)*. Refer to the *EOC* for the complete list of Copayments and Coinsurance.

Note: If Charges for Services are less than the Copayment described in the *EOC*, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum.

After you meet any applicable deductible and for the remainder of that Accumulation Period, you pay the applicable Copayment or Coinsurance, subject to the Plan Out-of-Pocket Maximum.

Drug Deductible

If your coverage includes a Drug Deductible, the deductible limits will be specified in *Your Benefits (Disclosure Form Part One)*. If you have a Drug Deductible, you must pay Charges for Services subject to the Drug Deductible during the Accumulation Period for certain drugs, supplies and supplements until you meet the Drug Deductible amount listed in *Your Benefits (Disclosure Form Part One)*. Once you meet the Drug Deductible, we will cover those Services at the applicable Copayment or Coinsurance amount. Refer to "Outpatient Prescription Drugs, Supplies, and Supplements" section of the *EOC* for Services that are subject to the Drug Deductible.

Plan Deductible

If your coverage includes a Plan Deductible, the deductible limits will be specified in *Your Benefits (Disclosure Form Part One)*. Note: The Plan Deductible amount for a High Deductible Health Plan is subject to increase if the U.S. Department of the Treasury changes the required minimum deductible.

If you have a Plan Deductible, you must pay Charges for Services subject to the Plan Deductible until you meet the Plan Deductible each Accumulation Period. The only payments that count toward a Plan Deductible are those you make for covered Services that are subject to the Plan Deductible. The Plan Deductible is for the calendar year unless a different Accumulation Period is specified in *Your Benefits (Disclosure Form Part One)*.

When the Copayment or Coinsurance for a particular Service is subject to the Plan Deductible you must pay Charges for those Services until you meet the deductible. Refer to the *EOC* for more information about which Services are subject to the Plan Deductible and an explanation of how the deductible works.

Refer to *Your Benefits (Disclosure Form Part One)* to learn if your coverage is subject to a Plan Deductible and the amount of the Plan Deductible. Refer to the *EOC* for more information about Plan Deductibles.

Plan Out-of-Pocket Maximum

The Plan Out-of-Pocket Maximum is the total amount of Cost Share you must pay in the Accumulation Period for covered Services that you receive in the same Accumulation Period. Refer to *Your Benefits (Disclosure Form Part One)* to find your Plan Out-of-Pocket Maximum. The Accumulation Period is the calendar year unless a different Accumulation Period is specified in *Your Benefits (Disclosure Form Part One)*. Refer to the *EOC* to learn which Services apply to the Plan Out-of-Pocket Maximum.

Accrual toward deductibles and out-of-pocket maximums

To see how close you are to reaching your deductibles, if any, and out-of-pocket maximums, use our online Out-of-Pocket Summary tool at **kp.org/outofpocket** or call Member Services. We will provide you with accrual balance information for every month that you receive Services until you reach your individual out-of-pocket maximums or your Family reaches the Family out-of-pocket maximums.

We will provide accrual balance information by mail unless you have opted to receive notices electronically. You can change your document delivery preferences at any time at **kp.org** or by calling Member Services.

Payment of Premiums

Your group is responsible for paying Premiums, except that you are responsible for paying Premiums if you have Cal-COBRA coverage. If you are responsible for any contribution to the Premiums that your group pays, your group will tell you the amount, when Premiums are effective, and how to pay your group (through payroll deduction, for example).

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may have to pay the cost of noncovered Services you obtain from Plan Providers or Non–Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for the covered Services you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. In some cases, you may be eligible to receive Services from a terminated provider in accord with applicable law.

Refer to "Completion of Services from Non–Plan Providers in the "Miscellaneous notices" section for more information.

Reimbursement for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and Emergency Ambulance Services

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider, or if you receive emergency ambulance Services, you are not responsible for any amounts beyond your Cost Share.

We will reduce any payment we make to you or the Non–Plan Provider by any applicable Cost Share. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement.

To file a claim, this is what you need to do:

- As soon as possible, obtain a claim form by:
  - calling Member Services toll free at **1-800-464-4000** (TTY users call **711**), or
  - through our website at **kp.org**
  - one of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for Services, you must send us our completed claim form for reimbursement. Please attach any bills and receipts from the Non–Plan Provider
- To request that a Non–Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the Non–Plan Provider for covered Services other than your Cost Share amount, please call Member Services toll free at **1-800-390-3510** for assistance
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, we may require documents such as travel documents or verification of your travel or itinerary.

Refer to the *EOC* for additional instructions, coverage information, exclusions, limitations, and dispute resolution for denied claims.

Termination of Benefits

Your group is required to inform the Subscriber of the date your membership terminates except as otherwise noted. You will be billed as a non-Member for any Services you receive after your membership terminates.

Membership will cease for you (the Subscriber) and your Dependents if:

- The contract between your group and Kaiser Permanente is terminated for any reason
- You are no longer eligible for group coverage
- You intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider (if you intentionally commit fraud, we may terminate your membership by sending written notice to the Subscriber; termination will be effective 30 days from the date we send the notice. If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution
- Your group fails to pay Premiums for your Family (or if your Family fails to pay Premiums for Cal-COBRA coverage for your Family)

Refer to the *EOC* for more information.

Continuation of Membership

Continuation of group coverage

You may be able to continue your group coverage for a limited time after you would otherwise lose eligibility, if required by law, under COBRA or Cal-COBRA. Refer to the *EOC* for more information.

If at any time you become entitled to continuation of group coverage such as Cal-COBRA, please examine your coverage options carefully before declining this coverage. Under the Affordable Care Act, individual plan coverage is available without medical review. However, the individual plan premiums and coverage are different from the premiums and coverage under your group plan.

If you are called to active duty in the uniformed services, you may be able to continue your coverage for a limited time after you would otherwise lose eligibility, if required by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Please contact your group if you want to know how to elect USERRA coverage and how much you must pay your group.

Individual Plan

If you want to remain a Health Plan member when your group coverage ends, you can enroll in one of our plans for individuals and families. The premiums and coverage under our individual plan coverage are different from those under your group coverage.

If you want your individual plan coverage to be effective when your group coverage ends, you must submit your application within the special enrollment period for enrolling in an individual plan due to loss of other coverage. Otherwise, you will have to wait until the next annual open enrollment period.

To request an application to enroll directly with us, please go to **kp.org** or call Member Services. For information about plans that are available through Covered California, visit **CoveredCA.com** or call Covered California at **1-800-300-1506** (TTY users call **711**).

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Member Services

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move
- How to replace your ID card

You can reach Member Services in the following ways:

Call **1-800-464-4000 (**English and more than 150 languages using interpreter services)
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
TTY users call **711**
24 hours a day, seven days a week (except closed holidays)

Visit Member Services office at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for addresses)

Write Member Services office at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for addresses)

Website **kp.org**

Dispute Resolution and Binding Arbitration

Member Services representatives can help you with unresolved issues at our Plan Facilities or by phone at **1-800-464-4000** (TTY users call **711**). They can also help you file a grievance orally or in writing. You can also submit a grievance electronically at **kp.org**. You must submit your grievance within 180 days of the date of the incident.

Independent medical review is available if you believe that we improperly denied, modified, or delayed Services or payment of Services, and that either (1) our denial was based on a finding that the Services are not Medically Necessary, or (2) for life-threatening or seriously debilitating conditions, the requested treatment was denied as experimental or investigational. Also, if you should file a grievance and you later need help with it because your grievance is an emergency, it hasn't been resolved to your satisfaction, or it's unresolved after 30 days, you may call the California Department of Managed Health Care toll free at **1-888-466-2219** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired for assistance.

Except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law, any dispute between Members, their heirs, or associated parties (on the one hand) and Health Plan, its health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising from your Health Plan membership, must be decided through binding arbitration. This includes claims for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration.

This is a brief summary of dispute resolution options. Refer to the *EOC* for more information, including the complete arbitration provision.

Renewal Provisions

Your group is responsible for informing you when its contract with Kaiser Permanente is changed or terminated. The contract generally changes each year, or sooner if required by law.

Principal Exclusions, Limitations, and Reductions of Benefits

Exclusions

The following are the principal exclusions from coverage. See the *EOC* for the complete list, including details and any exceptions to the exclusions. These exclusions or limitations do not apply to Services that are Medically Necessary

to treat mental health conditions or substance use disorders that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that are listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

- Care in a residential care facility except for Services covered under "Substance Use Disorder Treatment" and "Mental Health Services" in the *EOC*
- Care in an intermediate care facility, unless otherwise stated in the *EOC*
- Chiropractic Services, unless otherwise stated in the *EOC*
- Cosmetic Services, except for Services covered under "Reconstructive Surgery" and "Prosthetic and Orthotic Devices" in the *EOC*
- Custodial care, except for covered hospice care
- Dental and orthodontic Services and X-rays, except for Services covered under "Dental and Orthodontic Services" in the *EOC*
- Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies
- Experimental or investigational Services, except as required by law for certain clinical trials. You can request an independent medical review if you disagree with our decision to deny treatment because it is experimental or investigational (refer to the *EOC* for details about independent medical review and other dispute resolution options)
- Hearing aids, unless otherwise stated in the *EOC*
- Items and services that are not health care items and services, unless otherwise stated in the *EOC*
- Items and services to correct refractive defects of the eye (such as eye surgery or contact lenses to reshape the eye)
- Massage therapy, unless otherwise stated in the *EOC*
- Outpatient oral nutrition, such as dietary supplements, herbal supplements, formulas, food, and weight loss aids, unless otherwise stated in the *EOC*
- Physical examinations related to employment, insurance, licensing, court orders, parole, or probation, unless a Plan Physician determines that the Services are Medically Necessary
- Routine foot care Services that are not Medically Necessary
- Services not approved by the federal Food and Drug Administration ("FDA") that by law require FDA approval in order to be sold in the U.S., except for certain experimental or investigational Services, and as required by law for certain clinical trials
- Services performed by unlicensed people, except for behavior health treatment covered under "Behavioral Health Treatment for Autism Spectrum Disorder" in the *EOC*
- Services related to conception, pregnancy, or delivery in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate
- Services related to a noncovered Service, except for Services we would otherwise cover to treat complications of the noncovered Service
- Travel and lodging expenses, unless otherwise stated in the *EOC*
- Treatment of hair loss or growth

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a

Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest emergency department as described under "Emergency Services " in the "How to obtain care" section and we will provide coverage as described in that section.

Reductions

If you obtain a judgment or settlement from or on behalf of another party who allegedly caused an injury or illness for which you received covered Services, you must reimburse us to the maximum extent allowed under California Civil Code Section 3040. Note: This "Reductions" section does not affect your obligation to pay your Cost Share for these Services. Alternatively, we may file a subrogation claim on our own behalf against the other party. In addition to these other party liability claims by Kaiser Permanente, the contracts between Kaiser Permanente and some providers may allow these providers to recover all or a portion of the difference between the fees paid by Kaiser Permanente and the fees the provider charges to the general public for the Services you received.

Refer to the *EOC* for additional information and other reductions (for example, surrogacy arrangements and workers' compensation).

To Become a Member

We look forward to welcoming you as a Kaiser Permanente Member.

If you are eligible to enroll, simply return a completed enrollment application to your group. Be sure to ask your group for your group (purchaser) number and the date when your coverage becomes effective.

You can begin using our Services on your effective date of coverage. Again, if you have any questions about Kaiser Permanente, please call Member Services at **1-800-464-4000** (TTY users call 711) or you can refer to the *EOC* for details about eligibility requirements.

Persons barred from enrolling

You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

Miscellaneous Notices

Completion of Services from Non–Plan Providers

New Member
If you are currently receiving Services from a Non–Plan Provider in one of the cases listed below under "Eligibility" and your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective, you may be eligible for limited coverage of that Non–Plan Provider's Services.

Terminated provider
If you are currently receiving covered Services in one of the cases listed below under "Eligibility" from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's Services.

Eligibility
The cases that are subject to this completion of Services provision are:

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends
- Serious Chronic Conditions. We may cover these Services until the earlier of (1) 12 months from your membership effective date if you are a new Member; (2) 12 months from the termination date of the terminated provider; or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Mental health conditions in pregnant Members that occur, or can impact the Member, during pregnancy or during the postpartum period including, but not limited to, postpartum depression. We may cover completion of these Services for up to 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Care for children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child's membership effective date if the child is a new Member; (2) 12 months from the termination date of the terminated provider; or (3) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your membership effective date if you are a new Member or within 180 days of the termination date of the terminated provider

To qualify for this completion of Services coverage, all of the following requirements must be met:

- Your Health Plan coverage is in effect on the date you receive the Services
- For new Members, your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective
- You are receiving Services in one of the cases listed above from a Non–Plan Provider on your membership effective date if you are a new Member, or from the terminated Plan Provider on the provider's termination date
- For new Members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the Services of your current Non–Plan Provider
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside your Home Region Service Area (the requirement that the provider agree to providing Services inside your Home Region Service Area doesn't apply if you were receiving covered Services from the provider outside the Service Area when the provider's contract terminated)
- The Services to be provided to you would be covered Services under the *EOC* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from your membership effective date if you are a new Member, or from the termination date of the Plan Provider

Your Cost Share for completion of Services is the Cost Share required for Services provided by a Plan Provider as described in the *EOC*. **For more information about this provision or to request the Services or a copy of our "Completion of Covered Services" policy, please call** Member Services**.**

Drug formulary

The drug formulary includes a list of drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members in your Home Region Service Area. Our Pharmacy and Therapeutics Committee, which is primarily comprised of Plan Physicians and pharmacists, selects drugs for the drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature. The drug formulary is updated monthly based on new information or new drugs that become available. To find out which drugs are on the formulary for your plan, please visit our website at **kp.org/formulary**. If you would like to request a copy of the drug formulary for your plan, please call Member Services. Note: The presence of a drug on the drug formulary does not necessarily mean that it will be prescribed for a particular medical condition.

Drug formulary guidelines allow you to obtain a nonformulary prescription drug (those not listed on our drug formulary for your condition) if it would otherwise be covered by your plan and it is Medically Necessary. If you disagree with a Plan determination that a nonformulary prescription drug is not covered, you may file a grievance as described in the *EOC*.

Refer to *Your Benefits (Disclosure Form Part One)* to learn if you have coverage for outpatient prescription drugs.

Privacy practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means. You may request confidential communication by completing a confidential communication request form, which is available on kp.org under “Request for confidential communications forms.” Your request for confidential communication will be valid until you submit a revocation or a new request for confidential communication. If you have questions, please call Member Services.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions.
In addition, protected health information is shared with employers only with your authorization or as otherwise permitted by law.

We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. OUR *NOTICE OF PRIVACY PRACTICES* WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY

PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy, please call Member Services at **1-800-464-4000**. You can also find the notice at your local Plan Facility or on our website at **kp.org**.

Special note about Medicare

The information contained in this booklet is not applicable to most Medicare beneficiaries. Please check with your group to determine the correct pre-enrollment disclosure that applies to you if you are eligible for Medicare, and to learn whether you are eligible to enroll in Kaiser Permanente Senior Advantage.

Definitions

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable) and the Plan Out-of-Pocket Maximum. For example, the Accumulation Period may be a calendar year or contract year. The dates of your Accumulation Period are specified in *Your Benefits (Disclosure Form Part One)*.

Allowance: A specified amount that you can use toward the purchase price of an item. If the price of the items you select exceeds the Allowance, you will pay the amount in excess of the Allowance (and that payment will not apply toward your deductible, if any, or out-of-pocket maximum).

Charges: Charges means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of the Medical Group and Kaiser Foundation Hospitals' charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For air ambulance Services received from Non-Plan Providers when you have an Emergency Medical Condition, the amount required to be paid by Health Plan pursuant to federal law
- For other Emergency Services received from Non-Plan Providers (including Post-Stabilization Care that constitutes Emergency Services under federal law), the amount required to be paid by Health Plan pursuant to state law, when it is applicable, or federal law
- For all other Services received from Non-Plan Providers (including Post-Stabilization Services that are not Emergency Services under federal law), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, or (2) in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the Non-Plan Provider and Health Plan or, absent such an agreement, the usual, customary and reasonable rate for those services as determined by Health Plan based on objective criteria
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract Cost Share

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service. A summary of Copayments and Coinsurance is listed in *Your Benefits (Disclosure Form Part One)*. For the complete list of Copayments and Coinsurance, refer to the *EOC*.

Copayment: A specific dollar amount that you must pay when you receive a covered Service. Note: The dollar amount of the Copayment can be $0 (no charge). A summary of Copayments and Coinsurance is listed in *Your Benefits (Disclosure Form Part One)*. For the complete list of Copayments and Coinsurance, refer to the *EOC*.

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your cost Share for those Services will be Charges until you meet the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Dependent: A Member who meets the eligibility requirements as a Dependent as described in the *EOC*.

Drug Deductible: The amount you must pay under the *EOC* in the Accumulation Period for certain drugs, supplies, and supplements before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to *Your Benefits (Disclosure Form Part One)* to learn if your outpatient prescription drug coverage is subject to the Drug Deductible and the Drug Deductible amount.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that you reasonably believed that the absence of immediate medical attention would result in any of the following:

- Placing the person's health (or, with respect to a pregnant person, the health of the pregnant person or unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to themself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Emergency Services: All of the following with respect to an Emergency Medical Condition:

- A medical screening examination that is within the capability of the emergency department of a hospital or an independent freestanding emergency department, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the facility, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post-Stabilization Care and not Emergency Services)
- Post-Stabilization Care furnished by a Non-Plan Provider is covered as Emergency Services when federal law applies, as described under “Post-Stabilization Care” in the “Emergency Services” section of the *EOC*

EOC: The *Evidence of Coverage* document, including any amendments, which describes the health care coverage under Health Plan's *Agreement* with your group.

Family: A Subscriber and all of their Dependents.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. Health Plan is a health care service plan licensed to offer health care coverage by the Department of Managed Health Care. This *Disclosure Form* sometimes refers to Health Plan as "we" or "us."

Health Savings Account ("HSA"): A tax-exempt trust or custodial account established under Section 223 (d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary.

Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified High Deductible Health Plan and meet other tax law eligibility requirements.

Health Plan does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for a Health Savings Account.

High Deductible Health Plan ("HDHP"): A health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. The health care coverage summarized in this *Disclosure Form* has been designed to be an HDHP compatible for use with a Health Savings Account.

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.

Kaiser Permanente State: California, Colorado, District of Columbia, Georgia, Hawaii, Idaho, Maryland, Oregon, Virginia, and Washington.

Medical Group: For Northern California Region Members, The Permanente Medical Group, Inc., a for-profit professional corporation, and for Southern California Region Members, the Southern California Permanente Medical Group, a for-profit professional partnership.

Medically Necessary: For Services related to mental health or substance use disorder treatment, a Service is Medically Necessary if it is addressing your specific needs, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider

For all other Services, a Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Member: A person who is eligible and enrolled, and for whom we have received applicable Premiums. This *Disclosure Form* sometimes refers to a Member as "you."

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside your Home Region Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to your Home Region Service Area

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under the *EOC* in the Accumulation Period for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Plan

Deductible amounts are listed in *Your Benefits (Disclosure Form Part One)*. The Plan Deductible is for the calendar year unless a different Accumulation Period is specified in *Your Benefits (Disclosure Form Part One)*. If your coverage includes a Plan Deductible, refer to the *EOC* for a list of the Services that are subject to the Plan Deductible.

Plan Facility: Any facility listed in the enclosed facility listing or on our website at **kp.org/facilities** for your Home Region Service Area. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The information in this online directory is updated periodically. The availability Plan Facilities may change. If you have questions, please call Member Services at **1-800-464-4000** (TTY users call **711**).

Plan Hospital: Any hospital listed in the enclosed facility listing or on our website at **kp.org/facilities** for your Home Region Service Area. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The information in this online directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call Member Services at **1-800-464-4000** (TTY users call **711**).

Plan Medical Office: Any medical office listed in the enclosed facility listing or on our website at **kp.org/facilities** for your Home Region Service Area. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The information in this online directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call Member Services at **1-800-464-4000** (TTY users call **711**).

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay in the Accumulation Period for covered Services that you receive in the same Accumulation Period. Refer to the *Your Benefits (Disclosure Form Part One)* to find your Plan Out-of-Pocket Maximum. Refer to the *EOC* to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the directory on our website at **kp.org/facilities** for your Home Region Service Area for locations of Plan Pharmacies in your area. The information in this online directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call Member Services at **1-800-464-4000** (TTY users call **711**).

Plan Physician: Any licensed physician who is a partner or an employee of the Medical Group, or any licensed physician who contracts to provide Services to Members in your Home Region Service Area (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Health Plan designates as a Plan Provider in your Home Region Service Area.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the emergency department), an independent freestanding emergency department, or a skilled nursing facility after your treating physician determines that this condition is Stabilized. Post-Stabilization Care also includes durable medical equipment covered under the *EOC*, if it is Medically Necessary after discharge from an emergency department and related to the same Emergency Medical Condition. For more information about durable medical equipment covered under your plan, see “Durable Medical Equipment (“DME”) for Home Use” in the “Benefits” section of your *EOC*.

Premiums: The periodic amounts that your group is responsible for paying for your membership under the *EOC* except that you are responsible for paying Premiums if you have Cal-COBRA coverage.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 or each year and are currently the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Idaho, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at **kp.org** or call Member Services at **1-800-464-4000** (TTY users call **711**).

Service Area: For Members enrolled in the **Northern California Region,** the following ZIP codes below for each county are inside our Northern California Region Service Area:

- All ZIP codes in Alameda County are inside our Service Area: 94501-02, 94505, 94514, 94536-46, 94550-52, 94555, 94557, 94560, 94566, 94568, 94577-80, 94586-88, 94601-15, 94617-21, 94622-24, 94649, 94659-62, 94666, 94701-10, 94712, 94720, 95377, 95391

- The following ZIP codes in Amador County are inside our Service Area: 95640, 95669
- All ZIP codes in Contra Costa County are inside our Service Area: 94505-07, 94509, 94511, 94513-14, 94516-31, 94547-49, 94551, 94553, 94556, 94561, 94563-65, 94569-70, 94572, 94575, 94582-83, 94595-98, 94706-08, 94801-08, 94820, 94850
- The following ZIP codes in El Dorado County are inside our Service Area: 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Service Area: 93242, 93602, 93606-07, 93609, 93611-13, 93616, 93618-19, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-30, 93737, 93740-41, 93744-45, 93747, 93750, 93755, 93760-61, 93764-65, 93771-79, 93786, 93790-94, 93844, 93888
- The following ZIP codes in Kings County are inside our Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Service Area: 93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, 93720
- All ZIP codes in Marin County are inside our Service Area: 94901, 94903-04, 94912-15, 94920, 94924-25, 94929-30, 94933, 94937-42, 94945-50, 94956-57, 94960, 94963-66, 94970-71, 94973-74, 94976-79
- The following ZIP codes in Mariposa County are inside our Service Area: 93601, 93623, 93653
- All ZIP codes in Napa County are inside our Service Area: 94503, 94508, 94515, 94558-59, 94562, 94567, 94573-74, 94576, 94581, 94599, 95476
- The following ZIP codes in Placer County are inside our Service Area: 95602-04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95703, 95722, 95736, 95746-47, 95765
- All ZIP codes in Sacramento County are inside our Service Area: 94203-09, 94211, 94229-30, 94232, 94234-37, 94239-40, 94244, 94247-50, 94252, 94254, 94256-59, 94261-63, 94267-69, 94271, 94273-74, 94277-80, 94282-85, 94287-91, 94293-98, 94571, 95608-11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638-39, 95641, 95652, 95655, 95660, 95662, 95670-71, 95673, 95678, 95680, 95683, 95690, 95693, 95741-42, 95757-59, 95763, 95811-38, 95840-43, 95851-53, 95860, 95864-67, 95894, 95899
- All ZIP codes in San Francisco County are inside our Service Area: 94102-05, 94107-12, 94114-27, 94129-34, 94137, 94139-47, 94151, 94158-61, 94163-64, 94172, 94177, 94188
- All ZIP codes in San Joaquin County are inside our Service Area: 94514, 95201-15, 95219-20, 95227, 95230-31, 95234, 95236-37, 95240-42, 95253, 95258, 95267, 95269, 95296-97, 95304, 95320, 95330, 95336-37, 95361, 95366, 95376-78, 95385, 95391, 95632, 95686, 95690
- All ZIP codes in San Mateo County are inside our Service Area: 94002, 94005, 94010-11, 94014-21, 94025-28, 94030, 94037-38, 94044, 94060-66, 94070, 94074, 94080, 94083, 94128, 94303, 94401-04, 94497
- The following ZIP codes in Santa Clara County are inside our Service Area: 94022-24, 94035, 94039-43, 94085-89, 94301-06, 94309, 94550, 95002, 95008-09, 95011, 95013-15, 95020-21, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95076, 95101, 95103, 95106, 95108-13, 95115-36, 95138-41, 95148, 95150-61, 95164, 95170, 95172-73, 95190-94, 95196
- All ZIP codes in Santa Cruz County are inside our Service Area: 95001, 95003, 95005-7, 95010, 95017-19, 95033, 95041, 95060-67, 95073, 95076-77
- All ZIP codes in Solano County are inside our Service Area: 94503, 94510, 94512, 94533-35, 94571, 94585, 94589-92, 95616, 95618, 95620, 95625, 95687-88, 95690, 95694, 95696
- The following ZIP codes in Sonoma County are inside our Service Area: 94515, 94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-07, 95409, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492
- All ZIP codes in Stanislaus County are inside our Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322-23, 95326, 95328-29, 95350-58, 95360-61, 95363, 95367-68, 95380-82, 95385-87, 95397

- The following ZIP codes in Sutter County are inside our Service Area: 95626, 95645, 95659, 95668, 95674, 95676, 95692, 95836-7
- The following ZIP codes in Tulare County are inside our Service Area: 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in Yolo County are inside our Service Area: 95605, 95607, 95612, 95615-18, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
- The following ZIP codes in Yuba County are inside our Service Area: 95692, 95903, 95961

For Members enrolled in the **Southern California Region**, The ZIP codes below for each county are in our Service Area:

- The following ZIP codes in Imperial County are inside our Service Area: 92274-75
- The following ZIP codes in Kern County are inside our Service Area: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380, 93383-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581
- The following ZIP codes in Los Angeles County are inside our Service Area: 90001-84, 90086-91, 90093-96, 90099, 90134, 90189, 90201-02, 90209-13, 90220-24, 90230-32, 90239-42, 90245, 90247-51, 90254-55, 90260-67, 90270, 90272, 90274-75, 90277-78, 90280, 90290-96, 90301-12, 90401-11, 90501-10, 90601-10, 90623, 90630-31, 90637-40, 90650-52, 90660-62, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-35, 90840, 90842, 90844, 90846-48, 90853, 90895, 90899, 91001, 91003, 91006-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91182, 91184-85, 91188-89, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-11, 91313, 91316, 91321-22, 91324-31, 91333-35, 91337, 91340-46, 91350-57, 91361-62, 91364-65, 91367, 91371-72, 91376, 91380-87, 91390, 91392-96, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91495-96, 91499, 91501-08, 91510, 91521-23, 91526, 91601-12, 91614-18, 91702, 91706, 91711, 91714-16, 91722-24, 91731-35, 91740-41, 91744-50, 91754-56, 91759, 91765-73, 91775-76, 91778, 91780, 91788-93, 91801-04, 91896, 91899, 93243, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93560, 93563, 93584, 93586, 93590-91, 93599
- All ZIP codes in Orange County are inside our Service Area: 90620-24, 90630-33, 90638, 90680, 90720-21, 90740, 90742-43, 92602-07, 92609-10, 92612, 92614-20, 92623-30, 92637, 92646-63, 92672-79, 92683-85, 92688, 92690-94, 92697-98, 92701-08, 92711-12, 92728, 92735, 92780-82, 92799, 92801-09, 92811-12, 92814-17, 92821-23, 92825, 92831-38, 92840-46, 92850, 92856-57, 92859, 92861-71, 92885-87, 92899
- The following ZIP codes in Riverside County are inside our Service Area: 91752, 92028, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247-48, 92253-55, 92258, 92260-64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501-09, 92513-14, 92516-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599, 92860, 92877-83
- The following ZIP codes in San Bernardino County are inside our Service Area: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 92252, 92256, 92268, 92277-78, 92284-86, 92305, 92307-08, 92313-18, 92321-22, 92324-25, 92329, 92331, 92333-37, 92339-41, 92344-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-11, 92413, 92415, 92418, 92423, 92427, 92880
- The following ZIP codes in San Diego County are inside our Service Area: 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-46, 91950-51, 91962-63, 91976-80, 91987, 92003, 92007-11, 92013-14, 92018-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-61, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-86, 92088, 92091-93, 92096, 92101-24, 92126-32, 92134-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-61, 92163, 92165-79, 92182, 92186-87, 92191-93, 92195-99
- The following ZIP codes in Tulare County are inside our Service Area: 93238, 93261
- The following ZIP codes in Ventura County are inside our Service Area: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07, 93009-12, 93015-16, 93020-22, 93030-36, 93040-44, 93060-66, 93094, 93099, 93252

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area unless that other county is listed above and that ZIP code is also listed for that other county.

Note: We may expand your Home Region Service Area at any time by giving written notice to your group. ZIP codes are subject to change by the U.S. Postal Service.

Services: Health care services or items ("health care" includes both physical health care and mental health care) and behavioral health treatment covered under "Behavioral Health Treatment for Autism Spectrum Disorder" in the *EOC*.

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is 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 person from the facility. With respect to a pregnant person who is having contractions, when there is inadequate time to safely transfer them to another hospital before delivery (or the transfer may pose a threat to the health or safety of the pregnant person or unborn child), "Stabilize" means to deliver (including the placenta).

Subscriber: A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber.

Surrogacy Arrangement: An arrangement in which an individual agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the individual receives payment for being a surrogate. For the purposes of the *EOC*, "Surrogacy Arrangements" includes all types of surrogacy arrangements, including traditional surrogacy arrangements and gestational surrogacy arrangements.

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Latitude AI, LLC
2545 Railroad Street
Pittsburg, PA 15222

Summary Annual Report for the
Latitude AI LLC Welfare Benefit Plan

This is the summary annual report for the Latitude AI LLC Welfare Benefit Plan, EIN 81-4509755, Plan number 501 for the period September 1, 2022 to December 31, 2022. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has a contract with insurance carriers to pay claims incurred under the terms of the plan. See attached list of carriers. Total premiums paid during the plan year were $5,408,524.

Because they are so-called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending December 31, 2022, the premiums paid under such "experience-rated" contracts were $4,805,386, and the total of all benefit claims paid under these "experience-rated" contracts during the plan year was $5,678,817.

Your rights to additional information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report.
- Insurance information including sales commissions paid by insurance carriers

To obtain a copy of the full annual report, or any part thereof, write or call the office of Latitude AI, LLC, who is the plan administrator, 2545 Railroad Street, Pittsburg, PA, 15222, 412-904-1216. These portions of the report are furnished without charge.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan:

Latitude AI, LLC
Plan Sponsor
2545 Railroad Street
Pittsburg, PA 15222
81-4509755

and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to:

Public Disclosure Room
Room N-1513
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

Federal Statements
Latitude AI LLC Welfare Benefit Plan
Plan: 501

Summary Annual Report - Insurance Carrier Information

Carrier	Premiums Paid
CIGNA HEALTH AND LIFE INSURANCE COMPANY AND AFFILIATES	$ 4,805,386
FOUR EVER LIFE INSURANCE CO.	16,883
METLIFE LEGAL PLANS	7,329
KAISER FOUNDATION HEALTH PLAN INC.	250,263
UNUM LIFE INSURANCE COMPANY OF AMERICA	265,823
UNUM LIFE INSURANCE COMPANY OF AMERICA	62,840
TOTAL	$ 5,408,524

LATITUDE AI LLC
ERISA WRAP PLAN
&
SUMMARY PLAN DESCRIPTION

(Amended and Restated Effective January 1, 2024)

LATITUDE AI LLC ERISA WRAP PLAN & SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

INTRODUCTION

THIS EMPLOYEE BENEFIT PLAN is formally known as the Latitude AI LLC ERISA Wrap Plan, (the "Plan").

The purpose of the Plan is to consolidate the multiple insured and/or self-insured health and welfare benefit plans sponsored and maintained by the Employer into a single, comprehensive health and welfare plan, for ease of administration and reporting. This type of Plan is sometimes referred to as a "wrap" or "umbrella" plan. While this document is designed to accomplish such consolidation, it is not the only document comprising the Plan. Rather, the entire Plan document is actually a series of documents, consisting of this document plus the various contracts and/or booklets that describe the specific benefits, rights and features under the various welfare benefit programs that are consolidated in this Plan. Together, this and such other documents comprise both the official "Plan document" and the "Summary Plan Description."

This Plan is effective January 1, 2024, provided that certain provisions may have a different effective date as described elsewhere in the Plan, and amends and restates the existing comprehensive health and welfare plan maintained by the Plan Sponsor in its entirety.

This Plan will be maintained for the exclusive purpose of providing benefits to covered Employees and, where applicable, their Dependents, and is intended to comply with all applicable laws, including the Internal Revenue Code of 1986, as amended, and the Employee Retirement Income Security Act of 1974, as amended.

ARTICLE I
DEFINITIONS

The following terms, when used in this Plan, will have the following meaning, unless a different meaning is clearly required by the context. Capitalized terms are used throughout the Plan for terms defined by this and other sections.

Affiliated Employer

"Affiliated Employer" means any entity that is affiliated with the Employer or any entity that is part of a group of entities that includes the Employer and constitutes: (a) a controlled group of corporations (as defined in Section 414(b) of the Code); (b) a group of trades or businesses, whether or not incorporated, under common control (as defined in Section 414(c) of the Code); (c) an affiliated service group within the meaning of Section 414(m); or (d) any other entity required to be aggregated with the Employer pursuant to regulations under 414(o) of the Code. Any Affiliated Employers participating in the Plan are listed in the Affiliated Employer Appendix.

Appendix

"Appendix" or "Appendices" means each of the appendices to the Plan. Each Appendix and any document included or incorporated therein will be considered a part of the Plan and may be amended by the Employer at any time for any reason without the consent of any person except as otherwise provided by law.

Code

"Code" means the Internal Revenue Code of 1986, as amended, and including all regulations issued under that law.

Component Document and Component Program

"Component Document" means a written document identified in the Appendices and incorporated herein by reference. "Component Program" means the program of benefits described in a Component Document.

Covered Person

"Covered Person" means an Eligible Employee or eligible Dependent who elects coverage under

the Plan and has not for any reason become ineligible to participate in the Plan.

Dependent

A person is a "Dependent" of an Employee with respect to a benefit provided hereunder if such person is classified as a "Dependent" under the Component Document that describes such benefit and the classes of persons eligible therefore.

Eligible Employee

"Eligible Employee" means any Employee who meets the eligibility requirements under a Component Document. As described in the Eligibility Appendix or a Component Document, an Eligible Employee also includes proprietors, partners, corporate officers and directors, and retirees whether or not they are compensated by salary or wages. An Eligible Employee is an Eligible Employee only to the extent of, and only with respect to participation in, those portions of this Plan with respect to which he meets the eligibility requirements of the applicable Component Document.

Employee

"Employee" means any individual who is employed by an Employer, but (unless specifically included as an "Employee" under a Component Document) does not include any of the following:

(a) Persons classified and treated by an Employer as independent contractors; if someone so classified and treated is subsequently determined by the Employer or any governmental agency or court not to be an independent contractor, such person will not be considered an Employee until the day after the final determination that such person is not an independent contractor;

(b) Nonresident aliens who receive no United States source income from an Employer;

(c) Individuals included in a unit covered by a collective bargaining agreement unless the Employer and the collective bargaining unit have agreed upon coverage under a Component Document; and

(e) Temporary or seasonal employees classified as such on the Employer's payroll records.

Employer

"Employer" means the Plan Sponsor and any Affiliated Employers that are approved by the Plan Sponsor to participate in this Plan; provided, however, the Plan Sponsor shall have the exclusive power and responsibility to perform all settlor-type functions under Sections 5.1, 5.2, 7.1 and elsewhere in the Plan.

ERISA

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and including all regulations issued under that Act.

FMLA

"FMLA" means the Family and Medical Leave Act of 1993, as amended, and including all regulations issued under that Act.

Plan

"Plan" means this Latitude AI LLC ERISA Wrap Plan, formerly known as the Argo AI, LLC Welfare Benefit Plan, as amended from time to time.

Plan Administrator

"Plan Administrator" means the person or entity authorized to administer the Plan pursuant to Article V. If the Employer does not appoint a Plan Administrator, the Plan Administrator is the Employer.

Plan Sponsor

"Plan Sponsor" means Latitude AI LLC, formerly known as Argo AI, LLC, or any successor in interest.

Plan Year

"Plan Year" means the Plan's 12-month fiscal year beginning each January 1 and ending the ensuing December 31. The coverage periods for the underlying Component Programs may be different than the Plan's fiscal year.

PPACA

"PPACA" means the Patient Protection and Affordable Care Act of 2010, as amended, and including all regulations and other guidance under that Act.

USERRA

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and including all regulations issued under that Act.

ARTICLE II
PARTICIPATION

2.1 Eligibility and Enrollment

(a) Eligibility

Any person who is an Eligible Employee or Dependent under a Component Document will be considered a Covered Person in the Plan on the date such person, under the terms of such Component Document, acquires coverage for the benefit(s) described in such Component Document; in no event may an Eligible Employee or Dependent participate in this Plan with respect to a particular benefit provided under a Component Document until the date specified in such Component Document. The Eligibility Appendix reflects a *summary* of the eligibility rules that apply under the various Component Documents and benefit programs reflected in those documents. Other eligibility rules may be reflected in the Component Documents themselves, or other documents.

The Plan Sponsor in its discretion may designate different coverage effective dates for one or more Component Programs for reasonable classifications of Employees related to business transactions (e.g., a merger or acquisition), and such effective dates will be communicated to affected Employees.

(b) Enrollment

An Eligible Employee may elect participation in the Plan with respect to any or all benefits described in Article III with respect to which the Eligible Employee and/or their Dependent(s) are eligible for coverage under the terms of the applicable Component Document(s). If an Eligible Employee (on behalf of themself and/or an eligible Dependent) does not elect to participate (or elects to participate only with respect to some, but not all, benefits) when first eligible, they may not elect to participate (or elect to participate in those health benefits not selected) until the beginning of the next Plan Year, subject to Section 2.2 below and any change in enrollment rules under a Component Document or the qualified change in status rules under a Code Section 125 cafeteria plan.

A "qualified change in status" under a Code Section 125 cafeteria plan means an event with respect to an Employee that would allow the Employee to revoke or modify a pre-tax election during a coverage period, in accordance with IRS regulations or other IRS guidance. Code Section 125 and the regulations thereunder generally provide that existing elections may be modified or revoked under one or more of the following circumstances:

(a) If the Employee and/or his or her dependents are enrolling for group health coverage pursuant to HIPAA special enrollment rules;

(b) A change in the legal marital status of an Employee; a change in the number of an Employee's dependents; a change in employment status (including worksite) of the

Employee or his or her dependents; a dependent child ceasing to be eligible for dependent coverage; or a change in the place of residence of the Employee and/or his or her dependents. With respect to change in an Employee's election relating to accident or health coverage or group-term life insurance, an Employee's new pre-tax compensation reduction must be consistent with such event to the extent required by the rules and regulations of the Department of Treasury;

(c) If the Employee is required to enroll his or her child or foster child under an accident or health plan pursuant to a judgment, decree or order of a court;

(d) If the Employee or his or her dependents become entitled to or ineligible for Medicare (Part A or B) or Medicaid coverage (other than coverage consisting solely of coverage for pediatric vaccines);

(e) If there is a significant change in the cost or coverage of an accident or health plan; or

(f) If the Employee takes a leave pursuant to the Family and Medical Leave Act.

The Plan Administrator, in its discretion, will determine whether an Employee has incurred a qualified change in status based on all the relevant facts and circumstances and in accordance with the rules and regulations issued under Code Section 125.

2.2 Compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

The Plan will comply with the special enrollment and nondiscrimination provisions of HIPAA, with respect to those benefits subject to HIPAA. To the extent HIPAA is applicable, the Plan will not establish a rule for eligibility or set any premium or contribution rate based on whether the Employee is actively at work (including whether the Employee is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated as being actively at work, as described in the HIPAA portability rules. See also Articles IX and X.

2.3 Termination of Participation

Participation in a benefit provided under a Component Document will terminate as provided in such Component Document. Participation by a person in this Plan will terminate when the person is no longer covered for a benefit provided by any Component Document.

Notwithstanding the foregoing, and unless expressly provided to the contrary in a Component Document, coverage of any person under a Component Program may be terminated where the Plan Administrator determines that the person is ineligible for coverage; that enrollment was obtained, or benefits claimed or provided, pursuant at least in part to a misrepresentation pertaining to such person; that the person failed to supply information reasonably requested by the Plan Administrator; that premiums were not timely paid by the person or on the person's behalf; that the person failed to assist the Plan in its efforts to enforce its subrogation or reimbursement rights; or for any other reason where the Plan Administrator deems disenrollment is appropriate on account of the actions or inactions of the person (or any other person who acts or fails to act on behalf of the person). Where a Dependent is disenrolled due to such conduct, the Plan Administrator may in its discretion disenroll the Employee and/or one or more of the Employee's other Dependents where it appears such person(s) were complicit in the misrepresentation. Where an Employee is disenrolled due to such conduct, however, all enrolled Dependents will also be disenrolled.

Where coverage is terminated pursuant to the preceding paragraph, it may be terminated prospectively. Coverage may also be terminated retroactively to the date of (as applicable) the action giving rise to the termination or, where termination is due to ineligibility or failure to timely pay premium, to the date of the person's enrollment or, if later, the date the person

became ineligible; provided, however, that with respect to Component Programs subject to the PPACA, coverage shall be terminated retroactively only in the event of fraud or material misrepresentation (both of which are hereby expressly prohibited by this Plan), or to the extent otherwise permitted by the PPACA or guidance issued thereunder (including but not limited to failure to timely pay required premiums or contributions), and upon appropriate notice to the person as may be required under the PPACA Act or regulations.

2.4 Continuation Coverage Rights

(a) Health Care Coverages

Certain health care coverages under this Plan may be subject to coverage continuation rights under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), or similar state or federal law. Where that is the case, such coverage rights are described in the applicable Component Documents. A former Covered Person who is eligible to, and elects to, continue coverage under the applicable coverage continuation law, may continue to participate in this Plan to the extent provided under the coverage continuation law.

(b) FMLA

Notwithstanding any other Plan provision providing for an earlier termination of coverage, in the event participation in a health care benefit offered through this Plan would terminate due to the Eligible Employee taking a leave of absence pursuant to the FMLA, eligibility for such benefit will be continued for the lesser of: the period of the leave or the maximum period of leave required under the FMLA; provided, however, other provisions of this Plan or the Employer's employment policies may provide for more generous continued eligibility. Coverage will continue only as long as any required Employee contributions are timely made. Employees on leave must make the same contribution as is required for active Employees. Coverage under other welfare benefits (other than health benefits) will continue or terminate during a period of FMLA leave to the same extent as such benefits continue or terminate during periods of leave under similar circumstances (that is, paid or unpaid leave, as the case may be) that is not FMLA leave.

(c) USERRA

Notwithstanding any other Plan provision regarding termination of coverage, in the event participation in health benefits offered through this Plan would terminate due to the Eligible Employee taking a USERRA leave of absence, such benefits will be continued for the lesser of: the period of leave or 24 months. Provided, however, coverage will continue only as long as any required Employee contributions are timely made. Employees on a USERRA leave of less than 31 days must make the same contribution as is required for active Employees; Employees on a USERRA leave of 31 days or longer must pay up to 102% of the full cost (Employee and Employer contributions) of coverage, as determined by the Plan Administrator.

(d) State Mandated Continuation Coverage Rights

In addition to the continuation coverage rights discussed above, some states and localities provide additional continuation coverage rights, which the Plan will comply with to the extent applicable.

(e) Employer Approved Leaves of Absence

The Component Documents may include provisions relating to the continuation of coverage during an Employer-approved leave of absence, whether paid or unpaid. In addition, the Employer may have other established policies and procedures concerning such leaves. Eligible Employees should contact the Plan Administrator for additional information prior to the commencement of any such leave.

ARTICLE III
BENEFITS

3.1 Benefits Incorporated by Reference

The benefits offered under this Plan are set forth in the Benefit Program Appendix attached to this document.

Each Covered Person may elect to receive coverage under the benefits offered under this Plan, subject to any additional eligibility conditions provided under the applicable Component Document. The terms, conditions and limitations of benefits offered under this Plan are contained in the applicable Component Documents referenced in the Benefit Program Appendix and which are incorporated herein in full, as amended from time to time. The benefits and the method of providing them may change from time to time and will be reflected in the applicable Component Documents.

ARTICLE IV
FUNDING

4.1 Contributions

The benefits described in Article III will be funded by Employer contributions or Employee contributions, or a combination thereof, as determined from time to time by the Employer. Contributions will be paid to an insurance carrier or other third-party administrator or, with respect to a self-funded, self-administered benefit, amounts will be paid directly to or on behalf of a Covered Person.

If an insurer, health maintenance organization, pharmacy benefit manager or other party pays any rebate (including any medical loss ratio rebate pursuant to the Patient Protection and Affordable Care Act of 2010), allowance, credit, or other amount with respect to the Plan or an insurance policy relating to a Component Document (a "Recovery"), whether such Recovery be paid in cash or effected as a credit against future premium or similar payments in the current or ensuing year, the Recovery amount will not be an asset of the Plan, but instead will be retained by the Employer as part of the Employer's general assets, except as provided below or as otherwise may be required by law. Therefore, a Recovery will not reduce or offset contributions or other amounts paid by Employees (or Dependents) for coverage under the Plan and will not otherwise be shared with Employees (or Dependents). If a Recovery exceeds the total amounts paid by the Employer for medical coverage under the Plan for the relevant period, the excess amount may not be retained by the Employer but instead will be treated as an asset of the Plan to the extent required by applicable law.

4.2 Employee Contributions

Any Employee contributions may be deducted from an Eligible Employee's wages on a pre-tax basis (or after-tax basis if permitted by the Employer) and will be subject to the policies of the Employer and the terms and conditions of the particular Component Program(s) and any cafeteria plan maintained by the Employer pursuant to Section 125 of the Code, and will be forwarded by the Employer to an insurance carrier or other third-party administrator or, with respect to benefits that are paid directly by the Employer, amounts will be collected by the Employer and paid directly to or on behalf of a Covered Person.

With respect to self-insured benefits provided under the Plan, contributions from a Covered Person will be deemed to be applied first to the payment of benefits. The intent of this provision is to establish that, in a case where such contributions from all Covered Persons do not exceed the amount of self-insured benefits paid under the Plan, any administrative expenses related to the self-insured benefits will be deemed paid other than from contributions from Covered Persons.

ARTICLE V
ADMINISTRATION

5.1 Plan Administrator

The Plan Sponsor is the Plan Administrator of this Plan. The Plan Sponsor may delegate some or all of its duties and authority as Plan Administrator to one or more Employees, to a committee appointed by the Plan Sponsor, to a third-party claims administrator or such other persons as the Plan Administrator deems appropriate. The Plan Administrator may delegate duties and authority with respect to the different Component Programs to different persons with respect to each Component Program.

5.2 Duties and Authority of Plan Administrator

Except to the extent an insurance company, under the terms of a Component Document, retains for itself or any other third-party (other than the Employer) the duties and responsibilities described below, the Plan Administrator will have the following duties and responsibilities:

(a) Administrative Duties

The Plan Administrator will administer the Plan consistent with the nondiscrimination rules described later in this Article, for the exclusive purpose of providing benefits to Covered Persons and their beneficiaries. The Plan Administrator will perform all such duties as are necessary to supervise the administration of the Plan and to control its operation in accordance with the terms thereof, including, but not limited to, the following:

(i) make and enforce such rules and regulations as it will deem necessary or proper for the efficient administration of the Plan;

(ii) interpret the provisions of the Plan and determine any question arising under the Plan, or in connection with the administration or operation thereof, including questions of fact;

(iii) determine all considerations affecting the eligibility of any individual to be or become a Covered Person;

(iv) determine eligibility for and amount of benefits for any Covered Person;

(v) authorize and direct all disbursements of benefits under the Plan;

(vi) authorize the recovery of benefit payments made in error; and

(vii) delegate and allocate, specific responsibilities, obligations and duties imposed by the Plan, to one or more employees, officers or such other persons as the Plan Administrator deems appropriate.

(b) General Authority

The Plan Administrator will have all the powers necessary or appropriate to carry out its duties, including the discretionary authority to interpret the provisions of the Plan and the facts and circumstances of claims for benefits, and to decide questions of fact related thereto. Any interpretation or construction of or action by the Plan Administrator with respect to the Plan and its administration will be conclusive and binding upon all parties and persons affected hereby, subject to the exclusive appeal procedure set forth in Sections 5.7 and 5.8.

5.3 Forms

All forms (written or electronic) and other communications from any Covered Person or other person to the Plan Administrator required or permitted under the Plan will be in the manner prescribed from time to time by the Plan Administrator, will be mailed first-class mail or delivered to the location specified by the Plan Administrator, will be deemed to have been given and delivered to the location specified by the Plan Administrator, and will be deemed to have been given and delivered only upon actual receipt thereof. Each Covered Person will

submit such pertinent information as the Plan Administrator may specify. However, to the extent the terms of a Component Document provide for different or contrary rules in this regard, and such terms are permitted by law, the terms of the Component Document will control.

5.4 Examination of Documents

The Plan Administrator will make available to each Covered Person or beneficiary this Plan document, including the Appendices and Component Documents, for examination at reasonable times during normal business hours. In the event a Covered Person or beneficiary requests copies of documents, the Plan Administrator may charge a reasonable amount to cover the cost of furnishing such documents.

5.5 No Assets

Notwithstanding any Plan provision to the contrary, no assets will be segregated for the purposes of providing benefits under the Plan unless a separate trust has been established for the Plan. The Employer will pay benefits under this Plan out of its general assets, to the extent such benefits are not paid under the terms of insurance contracts.

5.6 Reports

The Plan Administrator will file or cause to be filed all annual reports, returns, and financial and other statements required by a federal or state statute, agency or authority within the time prescribed by law or regulation for filing said documents; and to furnish such reports, statements or other documents to such Covered Persons and beneficiaries as required by federal or state statute or regulation, within the time prescribed for furnishing such documents.

5.7 Claims Procedure

A Covered Person will apply for Plan benefits in the manner required by the Plan Administrator or its delegate, unless a claim is filed directly by a provider of benefits. A claim for reimbursement of expenses must be submitted in a manner and within the time period specified in the applicable Component Documents. Claims will be evaluated by the Plan Administrator or such other person or entity specified in the applicable Component Documents and will be approved or denied in accordance with the terms of the Plan including the Component Documents.

The following claims procedures will apply, but only to the extent the applicable Component Document does not apply at least as extensive procedures. If the claim and appeal rules in this document apply, they will be construed and applied in a manner consistent with applicable federal regulations as in effect on the date the claim was received:

(a) Notice of Action

Any time a claim for benefits receives an adverse determination, the Employee or beneficiary ("Claimant") will be given written notice of such action within the "applicable period" after the claim is filed, unless special circumstances require an extension of time for processing. If there is an extension, the Claimant will be notified of the extension and the reason for the extension within the initial applicable period.

If any urgent health care claim or pre-service health care claim is approved, the Claimant will be notified of such approval and provided sufficient information to understand the import of the approval.

An "adverse determination" means a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for a benefit, where the action is based on a determination of an individual's eligibility, a determination that a benefit is not a covered benefit, the imposition of an exclusion or limitation, or a determination that a benefit is experimental, investigational or not medically necessary or appropriate. An adverse determination includes retroactive rescission of coverage (for reasons other than failure to pay premiums or due to routine administrative delays in processing coverage additions and deletions).

(b) Categories of Claims, "Applicable Periods," and Extensions

(1) Other Claims

The "applicable period" for a benefit claim not described in subsections (2) to (6) below is 90 days after receipt of the claim by the Plan. If the Plan requires additional time to process the claim, it may extend the applicable period by up to 90 days, but the Plan Administrator or its delegate must notify the Claimant of the need for the extension prior to the beginning of any such extension period.

(2) "Urgent" Health Care Claims

Urgent health care claims are requests for verification or approval of coverage for health care or treatment where, if the request were not handled expeditiously the delay could jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to *severe pain* that cannot be adequately managed without the care or treatment that is the subject of the claim. The "applicable period" for an urgent care claim is no longer than the period necessary to decide the matter (that is, "as soon as possible"), but in no event longer than 72 hours. Whether a claim involves "urgent care" (as defined in federal regulations) will be determined by the Claimant's attending physician, and the Plan will defer to the judgment of the Claimant's physician.

If the Plan cannot render a decision within this timeframe because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan Administrator or its delegate must notify the Claimant within 24 hours of the specific information needed to complete the claim. The Claimant must be given at least 48 hours to provide the required information. Within 48 hours after the earlier of (1) the Plan's receiving the required information or (2) the expiration of the period afforded to the Claimant to provide the information, the Plan Administrator or its delegate must notify the Claimant of the Plan's benefit determination. The Claimant may agree to extend these deadlines.

An appeal of an adverse determination regarding an urgent care claim (where the claim is still an urgent care claim) must be decided as soon as possible, but no later than 72 hours after the Plan receives the request for review or appeal. Other requirements apply to the processing of appeals by non-grandfathered healthcare coverage subject to the Patient Protection and Affordable Care Act of 2010. See below.

(3) "Pre-Service" Health Care Claims

A pre-service health care claim is any request for approval of health care coverage for a service or item that under the terms of the Plan requires advance approval. The "applicable period" for a pre-service claim is 15 days after receipt of the claim by the Plan. The Plan Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Plan Administrator or its delegate must notify the Claimant within the timeframe of the reason for the extension and the date the Plan expects to render its decision.

If the Claimant has not followed the Plan's procedures for filing a pre-service claim, the Plan must notify the Claimant within 5 days of the proper procedures to be followed in order to complete the claim. Further, if the Plan cannot render a decision within 15 days because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension must describe the specific information needed to complete the claim; the Claimant must be given at least 45 days from receipt of the notice to provide the required information; and the Plan has 15 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree to extend these deadlines.

(4) "Concurrent" Health Care Claims

A concurrent health care claim may be either an urgent care claim or a pre-service claim. Generally, it is a claim for an ongoing course of health care treatment to be provided over a period of time or number of treatments. An adverse determination involving concurrent care must be made sufficiently in advance of any reduction or termination in treatment to allow the Covered Person to appeal the adverse determination. If a course of treatment involves urgent care, a request by the Claimant to extend the course of treatment must be decided as soon as possible, but not later than 24 hours after receipt of the request by the Plan, provided that the request is made at least 24 hours prior to the expiration of treatment.

Expiration of an approved course of treatment is not an adverse determination under these rules. However, any reduction or termination by the Plan of the course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments originally prescribed is an adverse determination and may be appealed. Notice must be provided in a reasonable time before the treatments will stop; however, the Plan is not required to allow the Claimant the 180 days to appeal the Plan's decision, before the Plan may terminate the treatment. Coverage must continue during the pendency of an appeal of an adverse determination involving a concurrent care claim to the extent required by, and in accordance with, applicable federal law.

(5) "Post-Service" Health Care Claim

A post-service health care claim is a claim that is not an urgent care, pre-service or concurrent care claim. The "applicable period" for a post-service claim is 30 days after receipt of the claim by the Plan. The Plan Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Plan Administrator or its delegate must notify the Claimant within the timeframe of the reason for the extension and the date by which the Plan expects to render its decision.

If the Plan cannot render a decision within 30 days because the Claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension must describe the specific information needed to complete the claim. The Claimant must be given at least 45 days from receipt of the notice to provide the required information. The Plan has 30 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree to extend these deadlines.

(6) Disability Benefit Claim

The "applicable period" for a disability benefit claim is 30 days after receipt of the claim by the Plan. If the Plan requires additional time to process the claim, it may extend the applicable period by up to two (2) thirty-day extensions, but the Plan Administrator or its delegate will notify the Claimant of the need for the extension prior to the beginning of any such extension period.

(7) Special Rule for Retroactive Health Care Coverage Rescissions

Where health care coverage subject to the Patient Protection and Affordable Care Act of 2010 is rescinded retroactively (for reasons other than failure to pay premiums or due to routine administrative delays in processing coverage additions and deletions), in addition to any other notice that may be required by these provisions the Plan will supply written notice of the rescission to each affected participant not fewer than 30 days in advance of the date the Plan takes action to actually rescind the coverage.

(c) Form and Content of Notice of Adverse Determination on Claims

If a claim is denied in whole or in part, notice of such adverse determination must be provided to the Claimant. Notice must be written or electronic; oral notice is permitted with respect

to urgent care claims, but only if written or electronic confirmation is furnished to the Claimant within three (3) days after the oral notice is provided.

The notice must include the following:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- if applicable, a description of any additional information needed for the Claimant to perfect the claim and an explanation of why such information is needed;
- a description of the Plan's review procedures, including the Claimant's right to bring a civil action under Section 502(a) of ERISA;
- (for health care and disability claims) a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;
- (for health care and disability claims) if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and
- in the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

(d) Right to Request Review

Any person who has had a claim for benefits denied in whole or in part by the Plan Administrator or its delegate, or is otherwise adversely affected by action of the Plan Administrator or its delegate, will have the right to request review by the Plan Administrator. Such request must be in writing, and must be made within 180 days (for health care and disability benefit claims) or 60 days (for other claims) after such person is advised of the Plan Administrator's (or its delegate's) action. If written request for review is not made within such 180-day (or 60-day, as the case may be) period, the Claimant will forfeit his or her right to review. The Claimant or a duly authorized representative of the Claimant may review all pertinent documents and submit issues and comments in writing. The Plan Administrator may prescribe a reasonable procedure under which a Claimant may designate an authorized representative.

(e) Review of Claim

The Plan Administrator or its delegate will then review the claim. The person or entity that reviews the claim must be a named fiduciary under the Plan, and (in the case of reviews of health care or disability claims) may not be the same person, or a person subordinate to the person, who initially decided the claim. If in the case of a health care or disability claim the adverse determination was based on medical judgment, the person handling the appeal must consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved, and such professional may not be the same professional who was consulted with respect to the initial action on the claim.

The person or entity deciding the appeal may hold a hearing if it deems it necessary and will issue a written or electronically disseminated decision reaffirming, modifying or setting aside its former action. The decision on appeal must be made within 72 hours for a claim involving urgent health care, 30 days for a pre-service health care claim, 45 days for a disability claim,

or 60 days for a post-service health care claim or claim for a benefit other than a health care or disability benefit; the time period begins to run on the date the appeal is received by the Plan. The Claimant may agree to extend these deadlines.

The decision on review may be delayed for up to 45 days (in the case of a disability benefit claim) or 60 days (in the case of a claim other than for a disability benefit) where special circumstances require the delay, and such delay is permitted by federal regulations. The Plan Administrator or its delegate will provide notice of the extension, and the reason therefore, to the Claimant prior to the end of the initial review period.

A copy of the decision will be furnished to the Claimant. The decision will set forth:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- a statement that the Claimant is entitled to receive without charge reasonable access to any document (1) relied on in making the determination; (2) submitted, considered or generated in the course of making the benefit determination; (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination; or (4) in the case of a group health Plan or disability Plan, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- a statement of any voluntary appeals procedures and the Claimant's right to receive information about the procedures as well as the Claimant's right to bring a civil action under Section 502(a) of ERISA;
- a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency." (However, this latter statement is not required if there is no alternative dispute resolution process (e.g., arbitration).)

The decision will be final and binding upon the Claimant and all other persons involved, except to the extent otherwise provided under applicable law.

(f) Additional Rules Applicable to Disability Claims

The following additional rules will apply to any claim or review of a denied claim for disability benefits submitted on or after April 2, 2018 (or a later effective date prescribed by Department of Labor Regulations).

- All written notices will be provided in a culturally and linguistically appropriate manner, and will include the following:
  - a statement that a copy of all documents, records and other information relevant to the claim is available to the Claimant, free of charge, upon request;

- a discussion of the Plan's decision, including (for example) an explanation of the basis for disagreeing with or not following the views of any disability determination regarding the Claimant by the Social Security Administration, health care professionals, or vocational professionals;

- if the denial is based on medical necessity, experimental treatment, or other similar exclusions or limitations, an explanation of the scientific or clinical judgment used in the decisions, or a statement that an explanation will be provided free of charge upon request; and

- a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the denial, or a statement that they do not exist.

- The claim will be decided in a way that ensures the independence and impartiality of Plan decision makers involved in the review process, including claims processors or medical experts, and avoids any conflicts of interest as set forth in Section 2560.503-1 of the Department of Labor regulations.

- No deference will be afforded to the initial adverse determination, and the review will be conducted by an appropriate named fiduciary who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

- In deciding an appeal that is based in whole or in part on a medical judgment, the Plan decision maker will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

- Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse determination will be identified, without regard to whether the advice was relied upon in making the determination.

- Any health care professional consulted in making a medical judgment will be an individual who was neither consulted with in connection with the adverse determination that is the subject of the appeal, nor the subordinate of any such individual.

- Any new or additional evidence considered, relied on, or generated by the Plan or decision maker in connection with a review of the denied claim will be disclosed to the Claimant as soon as possible, and in all cases before the Plan can issue an adverse benefit determination.

- Any new or additional rationale relied on by the Plan or decision maker in connection with the review of the denied claim will be disclosed to the Claimant as soon as possible and in all cases before the Plan can issue an adverse benefit determination.

5.8 Additional Requirements for Non-Grandfathered Health Care Coverage Subject to the Patient Protection and Affordable Care Act of 2010

For health care claims under non-grandfathered health care coverage subject to the Patient Protection and Affordable Care Act of 2010, the following additional rules apply.

(a) Additional Requirements for Notice of Initial Adverse Determination and Notice of Final Action on Internal Appeal

Any notice of initial adverse determination or notice of final action on an internal review of an

adverse determination must include the following additional information:

- the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and the treatment code and their corresponding meanings (the Plan will supply this information related to the diagnosis and treatment codes as soon as practicable following such a request, and will not consider such request to be a request for an internal appeal or, as applicable, external review);

- the standard, if any, used in denying the claim in whole or in part (i.e., a discussion of an applied "medical necessity" standard);

- a description of the available internal and external appeals procedures, including information about how to initiate an appeal; and

- the availability of—and contact information for—any applicable office of health insurance consumer assistance or ombudsman established under the Act to assist individuals with the internal claims and appeals and external review procedures.

The notices described above must be supplied in a "culturally and linguistically appropriate" manner, pursuant to and to the extent required by applicable federal regulations.

(b) Additional Requirements Related to Access to Information Pending Decision on Appeal

In connection with any appeal of an adverse determination, the Claimant or a duly authorized representative of the Claimant will have the right to examine the Claimant's claim file, and to present evidence and testimony as part of the review process. The Claimant will receive, free of charge, any new or additional evidence considered, relied upon or generated by the Plan in connection with its review of an appeal of an adverse determination, and any new or additional rationale the Plan intends to rely upon in deciding the internal appeal, sufficiently in advance of the final decision on the internal appeal to allow the Claimant an opportunity to respond prior to the decision.

(c) Additional Requirements Related to External Review of Final Action on Internal Appeal

Different external review rules apply depending on whether the relevant health care coverage is subject to a state insurance law external review requirement that meets standards specified in federal regulations, or whether the coverage is not subject to such a state law.

Where the relevant health care coverage is subject to a state standard that complies with applicable federal regulations (or is deemed to comply during any transition period under such regulations), such state standard will apply to the insurer (where the coverage is insured) or the Plan (where the coverage is self-insured). Where the relevant health care coverage is not subject to a state standard, or subject to a state standard that does not meet federal regulatory requirements (taking into account any period of deemed compliance during a transition period provided for under federal regulations), then the following rules apply to the Plan to the extent and as of the date required by applicable federal regulations:

(1) A Claimant may file a request for external review within 4 months of receipt of notice of an adverse determination (to the extent permitted by applicable law, however, the Plan may require the Claimant to exhaust any reasonable internal appeal process); for this purpose, and to the extent permitted by applicable federal regulations, an "adverse determination" means an adverse determination as defined elsewhere in these provisions, but only to the extent it involves medical judgment or a retroactive rescission of coverage.

(2) Within 5 business days following receipt of the request for external review, the Plan will determine whether:

- the Claimant was covered under Plan and applicable health care coverage when the health care item or service was requested (or provided, where the review is a for a post-service claim);

- the adverse determination was not due to ineligibility of the Claimant;

- the Claimant exhausted any required internal appeal process; and

- the Claimant has provided all information required.

(3) The Plan will issue notice to the Claimant within one business day after the Plan's preliminary review of the request for external review. If the Claimant is not eligible for external review, the notice must include reasons for ineligibility and contact information for the Employee Benefit Security Administration. If the request for external review is not complete, the notice must describe information that is needed and allow the claimant to complete or perfect his request within the four-month filing period described above or 48 hours, whichever is later.

(4) If the request for external review is appropriate, the Plan will refer the appeal to an Independent Review Organization (IRO), with which the Plan has contracted in accordance with applicable federal regulations. The IRO will conduct its review and supply appropriate notices in accordance with applicable federal standards. If the IRO reverses the Plan's decision, the Plan will provide coverage or payment upon receipt of notice of the IRO's decision, without delay and without regard to the Plan's intention to seek judicial review.

(5) The Plan will make available, to the extent required by and in accordance with applicable federal law, an expedited external review process where a Claimant receives an adverse determination or final internal adverse determination and where completion of an expedited internal appeal or standard external review would seriously jeopardize the life or health of the Claimant.

(d) No Conflicts of Interest

The Plan will adjudicate claims in a manner ensuring the independence and impartiality of those involved in decision-making. For example, the Plan may not hire, promote, provide incentives to or terminate the employment of individuals based on their support of a denial of benefits or on the number of claims denied.

5.9 Expenses

Unless specified otherwise in a Component Document, the Employer will pay all reasonable expenses that are necessary to operate and administer the Plan.

5.10 Bonding and Insurance

To the extent required by law, every fiduciary of the Plan and every person handling Plan funds will be bonded. The Plan Administrator will take such steps as are necessary to assure compliance with applicable bonding requirements. The Plan Administrator may apply for and obtain fiduciary liability insurance insuring the Plan against damages by reason of breach of fiduciary responsibility and insuring each fiduciary against liability to the extent permissible by law at the Employer's expense.

5.11 Nondiscrimination Rules

The Plan will comply with all applicable nondiscrimination rules under the Code and any other applicable law. Should the Plan be subject to nondiscrimination testing under the Code or any other applicable law, the Plan Administrator may make any decisions or elections, whether voluntary or required by law, necessary to facilitate such testing. Any elections required to be in writing (e.g., the designation of separate

testing plans, where disaggregation or aggregation of Component Programs or portions of Component Programs is permitted or required) will be stated from time to time in Appendices to the Plan, to the extent required by applicable law.

5.12 Qualified Medical Child Support Orders

The Plan will honor the terms of a Qualified Medical Child Support Order with respect to Component Programs that are subject to such Order. Qualified Medical Child Support Orders are typically issued in or after divorce proceedings, and may create or recognize the right of a child to be covered under this Plan (specifically, to be covered under a Component Plan providing health benefits).

Medical child support orders will be evaluated by the Plan Administrator or such other person or entity specified in the applicable Component Documents and will be approved or denied. The Plan Administrator (or such other person or entity specified in the applicable Component Documents) will, promptly after receiving a medical child support order, notify the participant and each child designated in the order. The notification will contain information that permits the child to designate a representative for receipt of copies of notices that are sent to the child with respect to a medical child support order.

Within forty (40) business days after receipt of the order (or, in the case a national medical support notice, the date of the notice) the Plan Administrator (or such other person or entity specified in the applicable Component Documents) will determine whether the order is a "qualified" medical child support order. Upon determination of whether a medical child support order is or is not qualified, the Plan Administrator (or such other person or entity specified in the applicable Component Documents) will send a written copy of the determination to the participant and each child (or, where an official of the state agency issuing the order is substituted for the name of the child, notify such official).

If the Plan Administrator (or such other person or entity specified in the applicable Component Documents) determines that the medical child support order is qualified, the participant, the child or his representative must furnish to the Plan Administrator or its designee any required enrollment information. In the case of a national medical support notice, the Plan Administrator or its designee will: (i) notify the state agency issuing the notice whether coverage is available to the child under the Plan and, if so, whether such child is covered under the Plan and either the effective date of such coverage or any steps to be taken by the child's custodial parent or an official of the state agency that issued the notice to effectuate such coverage, and (ii) provide the custodial parent (or, where an official of the state agency issuing the order is substituted for the name of the child, notify such official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

The participant is responsible for notifying the Plan Administrator of the necessary enrollment information within the timeframe(s) specified in the applicable Component Program, but generally, in no more than forty-five (45) days immediately following the date the determination was made that the order is a Qualified Medical Child Support Order. In the case of a national medical support notice, if there are multiple coverage options available to the child under the Plan the state agency issuing the notice will select an option, but if it fails to do so within twenty (20) days after the Plan Administrator's (or designee's) notice described in the preceding paragraph, the child will be enrolled under the Plan's default option (if any).

Unless the Qualified Medical Child Support Order provides otherwise, the participant will be responsible to make any required contribution to pay for such coverage. In no event will coverage provided under a Qualified Medical Child Support Order become effective for a child prior to the date the Order is received by the Plan.

If the Plan Administrator or its designee determines that the medical child support order

is not "qualified," a written determination to that effect will be furnished to the participant and the child or the child's representative. The participant or the child (or the child's representative) may appeal the determination to the Plan Administrator or its designee. Any request for review of a determination must be filed with the Plan Administrator or its designee within sixty (60) days after the Plan Administrator or its designee issues its original determination.

For purposes of this Section, a "Qualified Medical Child Support Order" is an order issued by a court having proper jurisdiction, or issued under an administrative process established under state law that has the force and effect of law under applicable state law and which creates or recognizes the existence of a child's rights to, or assigns to such child the right to, receive health benefits for which a Dependent is eligible under this Plan, provided such order clearly specifies: (i) the name and last known mailing address of the Employee, and the name and mailing address of each child covered by the order (to the extent provided in the order, the name and mailing address of an official of the state agency issuing the order may be substituted for the name and mailing address of the child); (ii) a reasonable description of the type of coverage to be provided by the Plan to each child, or the manner in which coverage is to be determined; (iii) the time period to which such order applies; and (iv) meets other legal requirements. A national medical support notice that meets (or, pursuant to federal regulations, is deemed to meet) the foregoing requirements will be considered a Qualified Medical Child Support Order.

ARTICLE VI
RIGHT TO RECOVERY, REIMBURSEMENT, SUBROGATION AND SET-OFF

6.1 Applicability

The provisions of this Article VI apply to the extent the reimbursement and subrogation terms of an applicable Component Document do not supply greater rights to the Plan. If the reimbursement and subrogation terms of an applicable Component Document supply greater rights, the terms of such Component Document will apply. For purposes of this Article, a Component Document is "applicable" if benefits under the Component Document are the subject of a reimbursement or subrogation claim by this Plan. For purposes of this Article, a law will not be considered an "applicable law" if it is preempted by ERISA.

6.2 Corrective Payments

To the extent permitted by applicable law, whenever payments that should have been made under this Plan in accordance with the coordination of benefits provisions have been made under any Other Plans (as defined under Section 6.9), this Plan will have the right to pay to any persons making such other payments any amounts they determine to be warranted in order to satisfy the intent of the coordination of benefits provisions. Amounts so paid will be deemed to be benefits paid under this Plan, and to the extent of such payments, this Plan will be fully discharged from liability.

6.3 Reimbursement

To the extent permitted by applicable law, whenever this Plan makes payments that together with the payments the Covered Person has received or is entitled to receive from any Other Plan or Person (as defined under Section 6.9), exceed the maximum amount necessary to satisfy the intent of this provision; or exceed, under the terms of this Plan, the benefits properly payable to or on behalf of the Covered Person, Plan, provider, or person to or for or with respect to whom the payments were made, this Plan will have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan Administrator in its sole discretion will determine:

(a) The Covered Person;

(b) If the Covered Person is an eligible Dependent or former eligible Dependent, the Covered Person or former Covered Person with respect to whom the Covered Person is or was an eligible Dependent;

(c) Any Other Plan, provider, or person to or for or with respect to whom such payments were made;

(d) Any insurance company or Other Plan or Person that should have made the payment; and

(e) Any other organizations.

Alternatively, the Plan Administrator or its designee may set-off the amount of such payments, to the extent of such excess, against any amount owing, at that time or in the future, under this Plan to one or more of the Covered Person, Plans, persons, providers, insurance companies, or other organizations as listed above.

For example, but not by way of limitation, if this Plan pays a claim submitted by a Covered Person or by a health care provider who treated the Covered Person, and the Plan Administrator or its designee later determines that the claim was for an expense not covered under this Plan, the Plan is entitled to recover the payment from the Covered Person or the provider, or to recover part of the payment from the Covered Person and part from the provider, or set-off the amount of the payment from amounts the Plan may owe in the future to the Covered Person or the provider, or both. This same rule applies if the Plan makes payment to a Covered Person or a provider of an expense that is a Covered Expense, but the amount so paid exceeds the amount the Plan requires be paid.

These reimbursement provisions also apply where this Plan makes payments of covered expenses incurred for treatment of an injury or sickness for which any Other Plan or Person is or may be liable, and where this Plan's subrogation provisions do not provide this Plan with a right to recover amounts this Plan pays or may pay for treatment of the injury or sickness. If the Other Plan or Person makes payment to or on behalf of a Covered Person as compensation for the injury or sickness, and this Plan is not subrogated with respect to the payment, this Plan is entitled to reimbursement from the Covered Person (or anyone who received such payment on behalf of the Covered Person), from the payment made by the Other Plan or Covered Person, in an amount equal to the lesser of (i) the benefits paid by this Plan for treatment of the injury or sickness, or (ii) the amount of the payment made by the Other Plan or Covered Person. This provision will not apply where the Other Plan is a medical plan with respect to which this Plan, pursuant to its coordination of benefits provisions, is the primary payer of the Covered Person's covered expenses.

These reimbursement provisions will not be construed to prevent the Plan, in its sole discretion, from obtaining full reimbursement from the Covered Person (or, in the Plan's sole discretion) any other person who received payment on behalf of the Covered Person, such as a parent or guardian) by, for example, apportioning the obligation to reimburse the Plan among the Covered Person and any other person, such as the Covered Person's legal counsel. The preceding sentence is specifically intended to avoid requiring the Plan, in order to obtain full reimbursement, to seek reimbursement from any person (such as the Covered Person's legal counsel) other than the Covered Person (or the Person, such as a parent or legal guardian, who received payment on behalf of the Covered Person) where the Plan can be made whole entirely from amounts actually received by the Covered Person (or the Person, such as a parent or legal guardian, who received such amounts on behalf of the Covered Person). This same rule will apply to the Plan's rights to set-off as described above.

In addition, where another Plan or Person pays compensation to or on behalf of a Covered Person for an injury or sickness for which another Plan or Person is or may be liable, and the Covered Person incurs (either before or after payment of such compensation) otherwise covered expenses for treatment of the injury or sickness, a special rule applies. In such a case, such otherwise covered expenses that were incurred after the date on which the compensation was paid, or which were incurred before such date but not paid by the Plan as of such date, will be excluded from coverage under the Plan to the extent of the excess (if any) of the compensation received by or on behalf of the Covered Person, over the covered expenses which the Plan has already paid for treatment of the injury or sickness.

This Plan will not be responsible for any costs or expenses (including attorneys' fees) incurred by or on behalf of a Covered Person in connection with any recovery from any Other Plan or Person unless this Plan agrees in writing to pay a part of those expenses. The characterization of any amounts paid to or on behalf of a Covered Person, whether in a settlement agreement or otherwise, will not affect this Plan's right to reimbursement and to characterize otherwise covered charges as excludable covered expenses pursuant to these provisions.

6.4 Subrogation

To the extent permitted by applicable law, the Plan will be subrogated, to the extent of benefits paid or payable by this Plan, to any monies (*i.e.*, "first dollar" monies) paid or payable by any Other Plan or Person by reason of the injury or sickness which occasioned or would occasion the payment of benefits by this Plan, whether or not those monies are sufficient to make whole the Covered Person to whom or on whose behalf this Plan made its payments or to whom or on whose behalf this Plan's payments are payable. The Plan will not be responsible for any costs or expenses, including attorneys' fees, incurred by or on behalf of a Covered Person in connection with any efforts to recover monies from any Other Plan, unless this Plan agrees in writing to pay a portion of those expenses. The

characterization of any amounts paid to or on behalf of a Covered Person, whether under a settlement agreement or otherwise, will not affect this Plan's right to subrogation and to claim, pursuant to such right, all or a portion of such payment.

These subrogation provisions will not be construed to prevent the Plan, in its sole discretion, from obtaining full satisfaction of its subrogation lien from the Covered Person (or, in the Plan's sole discretion) any other Person who received payment on behalf of the Covered Person, such as a parent or guardian) by, for example, apportioning liability for satisfaction of the subrogation lien among the Covered Person and any other Person, such as the Covered Person's legal counsel.

This Plan will also be subrogated to the extent of benefits paid under this Plan to any claim a Covered Person may have against any Other Plan or Person for the injury or sickness that occasioned the payment of benefits under this Plan. Upon written notification to the Covered Person, this Plan may (but will not be required to) collect the claim directly from the Other Plan or Person in any manner this Plan chooses without the Covered Person's consent. This Plan will apply any monies collected from the Other Plan or Person to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim up to the amount of the award or settlement. Any balance remaining will be paid to the Covered Person as soon as administratively practical. The Plan Administrator may, within its sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

6.5 Implementation

The Plan Administrator will determine which of the Plan's rights and remedies it is within the best interests of this Plan to pursue. The Plan Administrator may agree to recover less than the full amount of excess payments or to accept less than full reimbursement if (1) this Plan has made, or caused to be made, such reasonable, diligent and systematic collection efforts as are appropriate under the circumstances; and (2) the terms of such agreement are reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.

6.6 Subrogation/Reimbursement Agreement

To the extent permitted by applicable law, except as otherwise provided herein (*e.g.*, the coordination rules regarding automobile insurance), if a Covered Person incurs an injury or sickness under circumstances where compensation may be payable to the Covered Person by some Other Plan or Person (as defined in this Article), the Plan may agree to pay benefits for that injury or sickness to the extent otherwise payable under the Plan, provided the Covered Person or someone legally qualified and authorized to act for the Covered Person in writing:

(a) Consents to the Plan's subrogation of any recovery or right of recovery the Covered Person has with respect to the injury or sickness;

(b) Promises not to take any action that would prejudice the Plan's subrogation rights;

(c) Promises to reimburse the Plan for any such benefits payments to the extent that the Covered Person receives a recovery from another Plan or Person, irrespective of how the recovery is made or characterized, and irrespective of whether the recovery is sufficient to make the Covered Person whole. This reimbursement must be made within 30 days after the Covered Person (or anyone on his or her behalf) receives the payment; and

(d) Promises to cooperate fully with the Plan in asserting its subrogation rights and supply the Plan with any and all information and execute any and all documents the Plan may need for this purpose.

In the event the Covered Person fails to, or refuses to, execute whatever assignment, form or document requested by the Plan Administrator or its designee, the Plan will be relieved of any and all legal, equitable or contractual obligation for any benefits or Covered Expense incurred by the Covered Person and each member of the Covered Person's family, including claims then incurred but unpaid.

Nothing in this Reimbursement Agreement provision will be construed to prevent application of the provisions of the Reimbursement provisions above, regarding the Plan's exclusion of otherwise Covered Expenses which have not been paid at the time the Covered Person receives compensation for the injury or sickness that gave rise to the expenses.

6.7 Constructive Trust

In the event the Plan, pursuant to these reimbursement and subrogation provisions, is entitled under such provisions to be reimbursed for benefits it has paid for treatment of a Covered Person's sickness or injury, and where the Covered Person or someone (including an individual, estate or trust) on behalf of the Covered Person receives or is entitled to receive compensation for such sickness or injury from some other source, the Plan will have a constructive trust on such compensation to the extent of the benefits paid by this Plan. Such constructive trust will be imposed upon the person or entity then in possession of such compensation.

6.8 Right To Receive And Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this Plan or any Other Plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which the Plan Administrator deems to be necessary for such purposes, with respect to any person claiming benefits under this Plan. Any person claiming benefits under this Plan will furnish to the Plan Administrator such information as may be necessary to implement this provision.

6.9 Special Definitions

For purposes of this Article VI, the following special definitions will apply:

(a) "Covered Person" means a Covered Person as defined in Article I, or a participating coverage continuation beneficiary who meets the eligibility requirements for coverage as specified in this Plan and is properly enrolled under the Plan.

(b) "Other Plan" includes, but is not limited to, any of the following providing payments on account of an injury or sickness:

(i) Any group, blanket or franchise health insurance, or coverage similar to same;

(ii) A group contractual prepayment or indemnity Plan, or coverage similar to same;

(iii) A Health Maintenance Organization (HMO), whether group practice or individual practice association;

(iv) A labor-management trusted Plan or a union welfare Plan;

(v) An Employer or multiemployer Plan or Employee welfare benefit Plan;

(vi) A governmental medical benefit program;

(vii) Insurance required or provided by statute;

(viii) Automobile, no-fault, homeowners or general liability insurance (not merely the medical expense benefit provisions of such insurance);

(ix) Settlement or judgment proceeds (regardless of the manner in which such proceeds are characterized).

The term "Other Plan" does not include any individual health insurance policies or contracts, or public medical assistance programs such as Medicaid, except as otherwise provided herein. The term "Other Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of Other Plans into consideration in determining its benefits and that portion which does not.

(c) "Person" means any individual, association, partnership, corporation or any other organization.

ARTICLE VII
AMENDMENT AND TERMINATION

7.1 Amendment or Termination

The Employer establishes this Plan with the intention that it will be maintained indefinitely; however, the Employer reserves the right at any time and from time to time to amend any or all of the provisions of the Plan, or terminate the Plan and/or Employer contributions thereunder, in whole or in part, for any reason and without consent of any person and without liability to any person for such amendment or termination, provided that the payment of claims that are incurred at the time of any such amendment or termination will not be adversely affected.

Any amendment of the Plan will be made in writing and will be approved by the Employer and executed by a duly-authorized representative of the Employer, provided that an amendment of any of the Appendices may be made by the Plan Administrator or its authorized representative. Because the Plan can only be amended by a written instrument, no person may rely on any oral statements or representations by any other person that attempt or purport to alter the provisions of the Plan or the benefits described in this Summary or any other written Plan document. Nothing in this Plan will be construed to require continuation of this Plan with respect to existing or future Covered Persons or beneficiaries.

Any insurer providing benefits under this Plan under the terms of a Component Document may amend such Component Document as and to the extent provided therein.

Where a change to a Component Document affects the information described in one or more Appendix, then the Appendix may be updated in accordance with the change to the Component Document without resorting to the formalities of a formal amendment. For example, if a Component Document is amended or replaced with a similar document (e.g., a group insurance contract is replaced by a similar contract issued by the same or different insurer), or where the claims administrator for a particular Component Program is changed, the Employer may, without resorting to the formalities of a formal amendment, replace the Appendices attached hereto with Appendices reflecting the updated information regarding the Component Document or its issuer.

7.2 Exclusive Purpose of Providing Benefits to Covered Persons

The Employer establishes this Plan for the exclusive benefit of Covered Persons. No Plan amendment or termination will be made which would cause or permit benefits to be provided other than for the exclusive benefit of such individuals, unless such amendment is made to comply with federal or local law.

7.3 Surplus Assets After Plan Termination

If a benefit is terminated and surplus assets attributable to that benefit remain after all liabilities regarding such benefit have been paid, such surplus will revert to the Employer to the extent permitted by applicable law, unless

otherwise specified in the Component Documents for such benefit.

ARTICLE VIII
GENERAL PROVISIONS

8.1 Plan Interpretation

This Plan document, including the attached Appendices and Component Documents incorporated herein by reference, sets forth the provisions of this Plan. This Plan will be read in its entirety and not severed except as provided in Section 8.8. The provisions of this document will control over the provisions of any Component Document, except to the extent this document expressly provides to the contrary.

8.2 Participation by Affiliated Employers

The Employer may permit any of its Affiliated Employers to participate in one or more benefits under the Plan. An Affiliated Employer will be deemed to have adopted the Plan and become an "Employer" hereunder by making contributions under the Plan.

8.3 Non-Alienation of Benefits

Except as provided in Section 5.12 (Qualified Medical Child Support Orders) or as set below, no benefit, right or interest of any person hereunder will be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law.

Without limiting the preceding paragraph, a Covered Person may not assign to any party, including without limitation to a provider of healthcare services/items, such person's right to benefits under this Plan, nor may the Covered Person assign any administrative, statutory, or legal rights or causes of action he or she may have under ERISA, including, but not limited to, any right to make a claim for Plan benefits, to request Plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights will be void and unenforceable under all circumstances.

A Covered Person, however, may authorize the Plan to pay any healthcare benefits to a participating or non-participating provider of benefits under a Component Program. When a Covered Person authorizes the payment of benefits to a participating or non-participating provider, the Covered Person authorizes the payment of the entire amount of the benefits due on that claim. A Covered Person may not interpret or rely upon this discrete authorization or permission to pay any healthcare or other benefits to a participating or non-participating provider as the authority to assign any other rights under this Plan to any party, including, but not limited to, a provider of healthcare services/items.

8.4 No Additional Rights

No person will have any rights under the Plan, except as, and only to the extent, expressly provided for in the Plan. Neither the establishment or amendment of the Plan or the creation of any fund or account, or the payment of benefits, nor any action of the Employer or the Plan Administrator will be held or construed to confer upon any person any right to be considered or continued as an Employee, or, upon dismissal, any right or interest in any account or fund other than as herein provided. The Employer expressly reserves the right to discharge any Employee at any time.

8.5 Representations

The Employer does not represent or guarantee that any particular federal or state income, payroll, personal property, Social Security or other tax consequences will result from participation in this Plan. A Covered Person should consult with professional tax advisors to determine the tax consequences of participation.

8.6 Notice

All notices, statements, reports and other communications from the Employer to any

Employee or other person required or permitted under the Plan will be deemed to have been duly given when delivered (including facsimile transmission, email, telex, and telegrams) to, or when mailed by first-class mail, postage prepaid and addressed to, such Employee, or other person at the address last appearing on the Employer's records.

8.7 Masculine and Feminine, Singular and Plural

Whenever used herein, a pronoun will include the opposite gender and the singular will include the plural, and the plural will include the singular, whenever the context will plainly so require.

8.8 Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability will not affect any other provisions of the Plan, and the Plan will be construed and enforced as if such provision had not been included herein.

8.9 Governing Law

This Plan will be construed in accordance with applicable federal law and to the extent otherwise applicable, the laws of the Commonwealth of Pennsylvania.

8.10 Disclosure to Covered Persons

To the extent required by law, each Covered Person will be advised of the general provisions of the Plan and, upon written request addressed to the Plan Administrator, will be furnished any information requested regarding the Covered Person's status, rights and privileges under the Plan as may be required by law.

8.11 Accounting Period

The accounting period for the Plan will be the Plan Year.

8.12 Facility of Payment

In the event any benefit under this Plan will be payable to a person who is under legal disability or is in any way incapacitated so as to be unable to manage his or her financial affairs, the Plan Administrator may direct payment of such benefit to a duly appointed guardian, committee or other legal representative of such person, or in the absence of a guardian or legal representative, to a custodian for such person under a Uniform Gifts to Minors Act or to any relative of such person by blood or marriage, for such person's benefit. Any payment made in good faith pursuant to this provision will fully discharge the Employer and the Plan of any liability to the extent of such payment.

8.13 Correction of Errors

In the event an incorrect amount is paid to or on behalf of a Covered Person or beneficiary, any remaining payments may be adjusted to correct the error. The Plan Administrator may take such other action it deems necessary and equitable to correct any such error.

8.14 Workers' Compensation

This Plan is not in place of and does not affect any requirement for coverage by workers' compensation insurance or program; provided, however, the Plan Administrator in its sole discretion reserves the right to coordinate the receipt of workers' compensation benefits with any self-insured benefits available under this Plan and may determine that such workers' compensation benefits shall offset or otherwise reduce the benefits available under this Plan.

8.15 Managed Care Directories

To the extent any Component Document hereunder provides health benefits under one or more managed care networks, a directory of network providers may be furnished or made available to each Eligible Employee in writing or electronically. However, upon written request, each Eligible Employee will receive, at no cost, a written directory of network providers, which may be provided in a separate document.

8.16 Time for Bringing Actions Against the Plan

Notwithstanding any provision in this Plan document or the terms of a Component Document to the contrary, no legal action may be brought to recover from or with respect to this Plan (i) prior to the date the claimant has exhausted all administrative remedies under this Plan and applicable Component Documents, or (ii) after the date that is eighteen (18) months following the date the claimant has received a final decision on appeal with respect to such claim.

8.17 Newborns' and Mothers' Health Protection Act

With respect to Component Programs that would separately be considered group health plans, the Plan will comply with the Newborns' and Mothers' Health Protection Act. Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, 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 normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

8.18 CHIPRA Special Enrollment Rights

CHIPRA provides you with a 60-day special enrollment right to enroll in a Component Benefit that is a group health plan under the following two circumstances: (1) your coverage or coverage of your dependent under Medicaid or a state-sponsored children's health insurance program ("CHIP") terminates due to loss of eligibility; and (2) you or your dependent becomes eligible for state financial assistance under Medicaid or CHIP to help pay for coverage under the Employer's group health plan(s).

8.19 Mental Health Parity

Any financial requirements (such as deductibles, copayments, coinsurance and out-of-pocket expenses) and any treatment limitations (such as frequency of treatment, medical necessity determinations, number of visits and days of coverage) applied to mental health and substance abuse coverage under a Component Program that is a health plan may not be more restrictive than the limitations applied to comparable medical and surgical coverage under the health plan. More information is available in the Component Documents.

8.20 Women's Health and Cancer Rights

The health benefits available through the Plan will comply with the Women's Health and Cancer Rights Act of 1998, which requires the provision of coverage for breast reconstruction in connection with mastectomy as follows, subject to plan deductibles and coinsurance, if any:

- Reconstruction of the breast on which the mastectomy has been performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

8.21 Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act prohibits using genetic information to discriminate with respect to health benefits. The health plans and insurers are prohibited from (1) restricting enrollment or adjusting premiums based on genetic information; and (2) requiring or requesting genetic information or genetic testing prior to or in connection with enrollment.

8.22 Indemnity of Employees

To the extent any Employee or committee of Employees has been appointed to serve as the Plan Administrator, the Employer shall indemnify and hold each such individual harmless from any and all liabilities or expenses of any kind incurred by such individual in carrying out their administrative responsibilities under the Plan, except to the extent such liabilities or expenses result from the gross negligence or willful misconduct of the individual.

ARTICLE IX
HIPAA PRIVACY PROTECTIONS

9.1 Background

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes upon the portion of this Plan providing health benefits, and certain other entities, certain responsibilities to ensure that Protected Health Information ("PHI") pertaining to Covered Persons remains confidential, subject to limited exceptions in which PHI may be disclosed. "Protected Health Information" means health information (including oral information) that:

(a) is created or received by health care providers, health plans, or health care clearinghouses;

(b) relates to an individual's past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and

(c) identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

9.2 Applicability and Effective Date

The rules contained in this Article do not apply to the Plan or the Employer until such date as the HIPAA Privacy Regulations (45 C.F.R. § 160.101 et seq.) apply to the Plan. The rules only apply to the portions of the Plan that provide medical care (e.g., medical, dental and vision care), and only to the extent such benefits are not "excepted benefits" under the HIPAA Privacy Regulations. The Plan Administrator may make a "hybrid entity designation" under which it has identified portions of the Plan that engage in functions covered by the HIPAA privacy rules, and the portions that do not. To the extent permitted by law, where the Plan includes one or more fully insured health care Component Program(s), and one or more self-insured health care benefit Component Program(s), the mere fact that fully insured and self-insured health care benefits are bundled under this Plan will not be construed to subject any fully insured medical benefit (absent the Employer's acquisition of PHI with respect to the fully insured health care benefit) under this Plan to the same HIPAA privacy requirements that apply to the self-insured health care benefit Component Program(s).

9.3 Disclosure of PHI

Provided that the Plan (or the Employer on behalf of the Plan) provides to Covered Persons a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI to the Employer, the Plan may disclose PHI (relating to a Covered Person) to the Employer, as further described below, without the consent or authorization of the Covered Person. In no event may the Plan disclose PHI to the Employer, without the consent or authorization of the Covered Person or his authorized representative, for purposes of employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Employer.

The Plan may disclose PHI to the Employer, without the consent or authorization of the Covered Person, subject to the Employer's obligations described below in Section 9.4 for Plan administrative functions such as wellness initiatives under the Plan, quality assurance, claims processing, auditing, and monitoring. However, only the minimum amount of PHI

necessary to accomplish a particular Plan administration function may be disclosed to the person(s) performing such functions.

In addition to disclosing PHI to the Employer to allow the Employer to perform Plan administrative functions, the Plan may disclose certain limited summary health information to the Employer, without the consent or authorization of the Covered Person, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. "Summary health information" is health information that summarizes claims history, expenses, or types of claims by individuals, but from which has been removed at least 18 specific identifiers, including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers, and other identifiers. In addition, the Plan may disclose enrollment and disenrollment information to the Employer without the consent or authorization of the Covered Person.

9.4 Obligations of Employer Regarding Receipt and Use of PHI

As a condition of receiving PHI from the Plan for Plan administrative functions the Employer specifically agrees to:

(a) not use or further disclose the PHI other than as permitted by this Plan or as required by law, or as permitted by the Covered Person to whom the PHI relates;

(b) ensure that any agents or subcontractors to whom it shares or provides the PHI received from the Plan agree to these same restrictions and conditions;

(c) not use the PHI for employment-related actions or in connection with any of its other benefit plans without the consent or authorization from the Covered Person to whom the PHI relates;

(d) report to the Plan any improper uses or disclosures of the PHI;

(e) provide Covered Persons access to PHI that relates to them, allow them to request amendments to the PHI, and upon request provide Covered Persons an accounting of all disclosures of their PHI by the Employer (except for those disclosures with respect to which no accounting is required);

(f) make available to appropriate federal authorities the Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan; and

(g) return or destroy (to the extent feasible) all copies of the PHI received from the Plan once the Employer's need for which the PHI was requested no longer exists or, if this is not feasible, limit further uses and disclosures of the PHI.

9.5 Use And Disclosure Of PHI By The Employer; Dispute Resolution

When the Employer obtains PHI from the Plan for Plan administrative functions, the PHI will be provided to members of the Employer's designated HIPAA team, including the Employer's human resources/benefits department, payroll department and the Employer's chief financial officer and his designees. The persons in these departments, except as otherwise provided in a specific authorization granted by the Covered Person or his authorized representative to the Employer, will have access to and may use the PHI solely to perform Plan administrative functions that the Employer performs for or with respect to the Plan.

The Employer may use PHI that it receives from the Plan to carry out Plan administrative functions and may use summary health information for the purposes described in section above titled, "Disclosure of PHI." The Employer may also disclose PHI relating to a Covered Person, without the consent or authorization of the Covered Person, as required or as otherwise permitted by law. For example, the law allows PHI to be disclosed, without the consent or authorization of the Covered Person, to law

enforcement, public health, and judicial agencies in certain circumstances. PHI pertaining to a minor Covered Person may, to the extent permitted by local law, be disclosed to the Covered Person's parent or guardian without the consent or authorization of the minor. There are other situations in which PHI may be disclosed without the Covered Person's consent. For more information please review the Plan's Privacy Notice or see the Plan's Privacy Official.

In the event a Covered Person or any other person believes that the Employer or any of its agents have misused PHI disclosed to it or to them by the Plan, such persons may notify the Employer's Privacy Official (contact the Plan Administrator for more information regarding how to contact the Privacy Official), or may file a complaint as described in the Plan's Privacy Notice, a copy of which should have already been received (an additional copy is available from the Plan Administrator). If the complaint is filed with the Privacy Official the Privacy Official will investigate the complaint and the events and circumstances related to it, as provided in the Employer's Privacy Policy and Procedure.

ARTICLE X
HIPAA SECURITY PROTECTIONS

10.1 Background

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes upon this Plan and certain other entities certain responsibilities to ensure that Protected Health Information ("PHI") that is *electronic* Protected Health Information ("ePHI") pertaining to covered persons remains confidential, subject to limited exceptions in which ePHI may be disclosed.

"Protected Health Information" means health information that:

(a) is created or received by health care providers, health plans, or health care clearinghouses;

(b) relates to an individual's past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and

(c) identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

"Electronic Protected Health Information" is PHI that is transmitted by or maintained in electronic media, as defined in 45 C.F.R. § 160.103.

10.2 Applicability and Effective Date

The rules contained in this Article do not apply to the Plan or the Employer until such date as the HIPAA Security regulations contained in 45 C.F.R. § 160.101 *et seq.* apply to the Plan. To the extent permitted by law, where the Plan includes one or more fully insured health care Component Program(s), and one or more self-insured health care benefit Component Program(s), the mere fact that fully insured and self-insured health care benefits are bundled under this Plan will not be construed to subject any fully insured medical benefit (absent the Employer's acquisition of PHI with respect to the fully insured health care benefit) under this Plan to the same HIPAA privacy requirements that apply to the self-insured health care benefit Component Program(s).

10.3 Disclosure of ePHI

Provided that the Plan (or the Employer on behalf of the Plan) provides to covered persons a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI to the Employer, the Plan may disclose ePHI (relating to a covered person) to the Employer, as further described below, without the consent or authorization of the covered person. In no event may the Plan disclose ePHI to the Employer without the consent or authorization of the covered person or his authorized representative,

for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (although the Plan may disclose summary ePHI or enrollment-related ePHI to the Employer, without authorization, as further described below).

The Plan may disclose ePHI to the Employer, without the consent or authorization of the covered person, subject to the Employer's obligations described below (in the section titled, *Employer Obligations with Respect to ePHI Obtained from the Plan*) for Plan administrative functions such as wellness initiatives under the Plan, quality assurance, claims processing, auditing, and monitoring. However, only the minimum amount of ePHI necessary to accomplish a particular Plan administration function may be disclosed to the person(s) performing such functions.

In addition to disclosing ePHI to the Employer to allow the Employer to perform Plan administrative functions, the Plan may disclose certain limited electronic summary health information to the Employer, without the consent or authorization of the covered person, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. "Summary health information" is health information that summarizes claims history, expenses, or types of claims by individuals, but from which has been removed at least 18 specific identifiers, including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers, and other identifiers. In addition, the Plan may disclose electronic enrollment and disenrollment information to the Employer without the consent or authorization of the covered person.

10.4 Obligations of Employer Regarding Receipt and Use of ePHI

As a condition of receiving ePHI from the Plan for Plan administrative functions the Employer specifically agrees to:

(a) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation, between the ePHI and persons who have no legitimate need to access such ePHI, as required by 45 C.F.R. § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;

(c) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) Report to the Plan any security incident of which it becomes aware.

ARTICLE XI
COVERAGE CONTINUATION RIGHTS

11.1 Background

Eligible Employees and Dependents have the opportunity to continue their health coverage (e.g., medical, dental and vision, as the case may be) in certain instances where coverage would otherwise terminate. Such continuation coverage is as described in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and is therefore sometimes referred to as "COBRA Continuation Coverage."

11.2 Entitlement And Qualifying Events

Under COBRA, a covered Employee or covered Dependent may elect to continue health coverage if that coverage would otherwise terminate due to a "qualifying event." Qualifying events are:

(a) A covered Employee's termination of employment, for reasons other

than gross misconduct, or reduction in work hours;

(b) Death of the covered Employee;

(c) Divorce or legal separation of the covered Employee and his spouse;

(d) A covered eligible child's ceasing to satisfy the Plan's definition of eligible child; or

(e) A covered Employee's entitlement to Medicare.

11.3 COBRA Qualified Beneficiaries

A Qualified Beneficiary is an individual who is entitled to COBRA Continuation Coverage. In addition to those individuals covered under the Plan immediately preceding a qualifying event, a child born to a Qualified Beneficiary who is a former covered Employee or who is adopted by or placed for adoption with such a former covered Employee, during the Employee's period of Continuation Coverage, is also a Qualified Beneficiary.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event for certain retirees. If a proceeding in bankruptcy is filed by the Employer, and that bankruptcy results in the loss of coverage (if any) of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

11.4 Maximum Coverage Continuation Periods

Generally, coverage under COBRA may continue for up to:

(a) Eighteen (18) months for an Employee or Dependent whose coverage would cease because of the Employee's termination of employment or reduction in work hours; or

(b) Twenty-nine (29) months (i.e. 18 plus 11) for a disabled individual who:

(1) becomes entitled to the 18 months of continued coverage available after an Employee's termination of employment or reduction in work hours;

(2) is determined by the Social Security Administration to have been disabled on the date of that termination of employment or reduction in work hours or at any time during the first 60 days of COBRA Continuation Coverage; and

(3) notifies the Plan of that disability determination within 60 days after the person receives it and while still purchasing the first 18 months of COBRA Continuation Coverage.

Please note that a COBRA Qualified Beneficiary is eligible for this additional 11 months of coverage, even if not disabled, if he is entitled to COBRA Continuation Coverage due to the same qualifying event that entitles a disabled person to the additional 11 months of coverage.

(c) Thirty-six (36) months, for a divorced or widowed spouse, or a child who has ceased to be a "Dependent" under the terms of the Plan.

(d) Where due to a reduction in hours during a stability period (for example, from full-time to part-time or per diem status) an Employee's eligibility for coverage will terminate at the end of such or a subsequent stability period, the Employer's obligation to notify the plan administrator of the occurrence of the reduction in hours begins on the date of the loss of coverage, and the end of the maximum COBRA coverage period is measured from the date of the loss of coverage rather than from the earlier reduction in hours. The terms "measurement period" and "stability period" shall have the meanings as defined in the Employer's *Policy Document for Full-Time*

Employee Determinations Under the Patient Protection and Affordable Care Act ("PPACA Policy"). The foregoing policy, if adopted by the Employer, will be applied on a uniform and consistent basis among all similarly situated Employees.

Special COBRA rules apply to COBRA continuation coverage under the health flexible spending account ("FSA"). Notwithstanding the foregoing, the duration for which a qualified beneficiary may purchase COBRA coverage under a health FSA depends on a number of factors. In most cases COBRA coverage is not available beyond the end of the 12-month FSA coverage period in which the qualifying event occurred. In addition, if at the time of the qualifying event the Eligible Employee has received health FSA benefit payments (during the 12- month coverage period) in an amount *exceeding* his or her contributions to the health FSA for that coverage period, then the qualified beneficiary is not eligible for COBRA coverage at all under the health FSA.

However, if the maximum amount of benefits available to the Eligible Employee under the health FSA exceeds two times his or her salary reduction contribution for the year or, if greater, the salary reduction contribution plus $500, COBRA coverage can continue for 18 months (for qualifying events that are a termination of employment (for reasons other than death) or reduction in work hours) or 36 months (for other qualifying events). If a qualified beneficiary is disabled (within the meaning of the Social Security Act) at the time of a qualifying event that is a termination of employment (for reasons other than death or gross misconduct) or reduction in hours, or is so disabled during the first 60 days of COBRA coverage following such a qualifying event, COBRA coverage for that beneficiary—and any other qualified beneficiary affected by the same qualifying event can continue for up to 29 months. Where there are multiple qualifying events the 18- or 29-month limit may be extended to 36 months.

If a qualified beneficiary is eligible for and chooses COBRA coverage he or she is eligible for reimbursement, for covered claims incurred after the qualifying event but during the same 12-month coverage period in which the qualifying event occurred, in an amount up to the maximum amount of reimbursement selected by the Eligible Employee on his or her health FSA benefit election form for that 12-month coverage period, *minus* the amount of reimbursements made to the Eligible Employee for the 12-month coverage period up to the date of the qualifying event. If COBRA coverage can continue into subsequent 12-month coverage periods (under the rules in the preceding paragraph), the qualified beneficiary must make an election—prior to the beginning of the 12-month coverage period—concerning the benefits he or she wants to have available for that new 12-month coverage period.

11.5 Special Second Election Period for Certain Trade-Displaced Individuals Who Did Not Elect COBRA Coverage

Special COBRA rights may apply to Employees who lose health coverage as a result of termination or reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act. These special rules may expire or be reinstated from time to time pursuant to sunset provisions under the law. Employees who believe they may be impacted by the Trade Act should contact the Plan Administrator for additional information.

11.6 Multiple Qualifying Events

If a Dependent is eligible to choose and chooses to continue coverage under these provisions after an Employee's termination of employment or reduction in work hours, and then another COBRA qualifying event (other than termination of employment or reduction in work hours) occurs during the original COBRA Continuation Coverage period, that Dependent may continue coverage for up to 36 months, measured from the date of the initial qualifying event. However, for an event to operate as a *second* qualifying event, it must be an event that would have triggered a loss of coverage had it been the *initial* qualifying event. In no case will any period of COBRA Continuation Coverage

exceed 36 months. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent, in writing, to the appropriate person described in Section 11.9. Please note that for the Employee's Medicare entitlement to be considered a second qualifying event for eligible Dependents, the Plan must provide that Medicare entitlement causes a loss of coverage for Dependents.

11.7 Special Continuation of Coverage Period for Medicare Entitlement

When an individual becomes entitled to Medicare and then, within 18 months thereafter, experiences a qualifying event that is loss of coverage due to termination of employment or reduction in work hours, the COBRA Continuation Coverage period for the Dependent spouse or Dependent children may continue for up to 36 months from the date of the Medicare entitlement.

11.8 Early Termination Of COBRA Coverage

Once a COBRA Qualified Beneficiary elects to continue coverage, coverage may continue for the period described above, unless:

(a) In the case of a person entitled to 29 months of COBRA Continuation Coverage (due to his or another person's disability), the Social Security Administration determines that he (or such other person) is no longer disabled, in which case the extended Continuation Coverage will cease on the first day of the month that begins more than 30 days after the Social Security Administration makes such a determination;

(b) If the person becomes entitled to Medicare, after the date he elects Continuation Coverage;

(c) The person fails to make a required monthly payment within the 30 day grace period pursuant to this provision;

(d) The person becomes covered - after the date he elects Continuation Coverage - under another employer group health plan (because of employment or otherwise) and that coverage contains no exclusion or limitation with respect to any pre-existing condition;

(e) The person becomes covered - after the date he elects Continuation Coverage - under another group health plan (because of employment or otherwise) that contains an exclusion or limitation with respect to a pre-existing condition which is nullified, waived or does not apply because of the Health Insurance Portability and Accountability Act (HIPAA) rules; or

(f) The Plan is terminated and the Employer maintains no group health plan for any of its active Employees.

11.9 Notification Of A Qualifying Event

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of the Employee's employment or reduction of hours of employment, his death, the employer's commencement of a proceeding in bankruptcy with respect to a retiree (if applicable), or his enrollment in Medicare (Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events (of course, where the Plan Administrator is the Employer, there's no need for the Employer to notify itself of these events).

A COBRA Qualified Beneficiary must notify the Plan Administrator within 60 days of a divorce or legal separation, of a child ceasing to meet the Plan's definition of "Dependent", or of the Social Security Administration's determination of disability. In addition, if the person is a disabled individual who obtained 29 months of COBRA Continuation Coverage, he must notify the Plan Administrator of any determination by the Social Security Administration that he is no longer disabled. Notification to the Plan Administrator must be

made within 30 days of the date such determination is made.

Notice for the qualifying events described above must be sent, in writing (describing the qualifying event and the date it occurred) to the Plan Administrator or designated COBRA administrator.

11.10 Benefits That May Continue

If a COBRA Qualified Beneficiary elects COBRA Continuation Coverage, the coverage will be identical to the health coverage then being provided under the Plan to Eligible Employees or, if in the case of a Dependent, to covered Dependents of Eligible Employees. COBRA Qualified Beneficiaries do not have to prove insurability to choose continuation coverage, but are required to pay for it.

11.11 Application And Payment Procedures

After a COBRA qualifying event (and the provision of any notice required by COBRA Qualified Beneficiary, as described in Section 11.9), the Plan Administrator will send or cause to be sent a more detailed notice and an application for continued coverage. To continue coverage under COBRA, a COBRA Qualified Beneficiary must complete and return the application to the Plan Administrator or its designee within 60 days from the later of the date the application is sent or the date coverage would otherwise terminate.

Payment for the period from the date coverage would otherwise terminate through the 45th day after COBRA Continuation Coverage is elected must be made by that 45th day (for example, if a person elects COBRA Continuation Coverage on the 30th day of the 60-day election period, he must make his first payment by the 45th day after he elected COBRA Continuation Coverage (or the 75th day following the start of an election period), and the payment must be for the period of COBRA Continuation Coverage from the date he would otherwise lose coverage to that 75th day). Thereafter, payments must be made within thirty (30) days after the monthly premium due date to be considered timely. The Plan will terminate coverage as of the qualifying event, but will reinstate it retroactively to the date of the qualifying event if a timely election for COBRA Continuation Coverage, and timely initial payment, are made.

The monthly cost of COBRA Continuation Coverage will be set for 12-month periods, and will not exceed 102% of the cost of coverage under the Plan for similarly situated Covered Persons. However, if a person qualifies for periods of extended coverage due to a disability (whether his or another Qualified Beneficiary's), the monthly COBRA premium during the period of extended coverage may be 150% of the cost of coverage under the Plan for similarly situated Covered Persons, depending on whether the disabled person continued coverage during the extended coverage period.

Please note that the terms of the Component Documents might set forth slightly different procedures for applying and paying for COBRA Continuation Coverage, or providing notice of certain qualifying events, or for other rights and obligations regarding COBRA Continuation Coverage. In that case the terms of the Component Document will control over this Article XI, to the extent the terms of the Component Document are consistent with applicable law.

11.12 Questions and More Information

A Covered Person may contact the Plan Administrator or COBRA administrator if he or she has any questions concerning COBRA continuation rights. Covered Person may also obtain information about their rights under ERISA, including COBRA, the Health Insurance Portability or Accountability Act (HIPAA), and other laws affecting group health plans, by contacting the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Each Covered Person must keep the Plan Administrator informed of any changes in the addresses of family members. A copy of any notices sent to the Plan Administrator should be retained by the Covered Person.

ARTICLE XII
STATEMENT OF ERISA RIGHTS

12.1 Covered Persons' Rights

As an Eligible Employee covered under the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all covered Eligible Employees will be entitled to:

(a) Receive Information About Your Plan and Benefits:

(1) 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 Benefit Security Administration.

(2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report. The Plan Administrator is normally required by law to furnish each participant with a copy of this summary annual report.

(b) Continue Group Health Plan Coverage:

Continue health care coverage for yourself, covered spouse or other Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your covered Dependents may have to pay for such coverage. Review this document and the Component Documents for the rules governing your COBRA continuation coverage rights.

(c) Prudent Actions by Plan Fiduciaries:

In addition to creating rights for covered Eligible Employees, ERISA imposes duties upon the people who are 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 Covered Persons. 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.

(d) Enforce Your Rights:

(1) If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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.

(2) If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If 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.

(e) 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, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.

PLAN DESCRIPTION APPENDIX

Plan Name:	Latitude AI LLC ERISA Wrap Plan
Plan Number:	501
Type of Plan:	Welfare benefit plan
Plan Year:	12-month period beginning January 1 and ending December 31
Plan Sponsor:	Latitude AI LLC 2545 Railroad Street, Suite 400 Pittsburgh, PA 15222 412-652-2871
Plan Sponsor Tax Identification Number:	92-1130676
Affiliated Employers:	See the Affiliated Employer Appendix
Plan Administrator and Named Fiduciary:	Latitude AI LLC 2545 Railroad Street, Suite 400 Pittsburgh, PA 15222 412-652-2871
Claims Administrator:	Unless otherwise described in the Component Document, the claims administrator is the insurer or third party administrator identified in the Benefit Program Appendix.
Sources of Contributions:	Employee contributions and Employer contributions.
Funding Medium:	Contributions under the Plan may consist of both Employer contributions and Employee contributions. Employee contributions for coverage are paid through payroll deduction.

Type of Administration:	Administered according to the Component Documents. Some benefits under the Plan are insured by one or more insurance companies. The Benefit Program Appendix describes the various benefits, whether they are insured or self-insured, and the identity of the insurance companies and/or third-party administrators. With respect to benefits under the Plan which are self-insured, those benefits may be administered by a third-party administrator, including an insurance company. In those cases where an insurance company has been hired to administer a self-insured plan, the insurance company does not insure or guarantee the benefits that it administers; see the Benefit Program Appendix for the identity of the third-party administrator(s). The Employer may maintain a stop-loss or reinsurance policy to protect the Employer against catastrophic loss under the comprehensive medical benefit program offered under this Plan. However, the stop-loss insurance merely reimburses the Employer for benefits it funds under the program, and is not to be construed as "insuring" the comprehensive medical benefits under the program.
Agent for Legal Process:	Service of legal process may be made upon the Plan Administrator.

BENEFIT PROGRAM APPENDIX

(Updated effective January 1, 2024)

The terms, conditions and limitations of the benefits offered under this Plan are contained in the Component Documents listed from time to time in this Appendix, which are incorporated herein by reference.

Component Program	**Insured or Self-Insured**	**Insurance Carrier or Administrator**
Medical/Rx	Insured Insured	Cigna Kaiser Permanente (California Employees only)
Health Savings Accounts (HSAs)	In accordance with Department of Labor (DOL) Field Assistance Bulletin 2004-1 and other DOL guidance, Health Savings Accounts are not subject to the requirements of ERISA. Accordingly, this Plan document will be interpreted and construed in accordance with the DOL guidance and any references to ERISA in this document will not apply to the Health Savings Accounts.	Cigna (HSA Bank)
Dental	Self-Insured	Delta Dental of PA
Vision	Self-Insured	Cigna
Long Term Disability	Insured	UNUM
Short Term Disability	Self-Insured	UNUM
Group Term Life	Insured	UNUM
Supplemental Term Life	Insured	UNUM
AD&D	Insured	UNUM
Supplemental AD&D	Insured	UNUM
Business Travel and Accident	Insured	GeoBlue
Employee Assistance Plan (EAP)	Insured	Workplace Options
Flexible Benefits Plan (Health FSA)	Self-Insured	Surency
Prepaid Legal	Insured	MetLife

ELIGIBILITY APPENDIX

(Updated effective January 1, 2024)

The various Component Programs may include eligibility rules in addition to those outlined below. Employees should review the underlying Component Documents and should contact the Plan Administrator with any questions.

Component Program(s)	**Eligibility**
Medical/Rx Dental Vision	Eligible Employees: All Employees classified by the Employer as benefits eligible employees on the Employer's books and records (generally working 30 or more hours per week), and all Employees classified by the Employer as part-time exempt employees on the Employer's books and records (generally working 20 or more hours per week) are eligible for coverage.* Effective Date of Employee Coverage: Employee coverage begins on the date of hire.* Termination Date of Employee Coverage: Employee coverage terminates at the end of the month in which termination of employment occurs.* **Notwithstanding any provision in the Plan to the contrary, an Employee who is determined to be a full-time Employee for purposes of complying with the employer-shared responsibility rules under the PPACA will be eligible for medical coverage for the duration of the applicable stability period except as otherwise provided under the Employer's PPACA policy and as permitted by law. Further, coverage for any such full-time Employee will commence (provided the Employee timely enrolls) no later than the first day of the stability period immediately following the measurement period during which the Employee established full-time status. Coverage for such an Employee shall terminate at the end of the last day of the last PPACA stability period with respect to which the Employee is considered a PPACA full-time Employee.* Eligible Dependents: An Eligible Employee may also elect coverage for the following Dependents: ● Spouse, including a common law spouse; ● Same or opposite sex domestic partner; ● Same or opposite sex civil union partner; ● Children of the Employee, including biological children, step-children, foster children, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26, except there is no limiting age for mentally or physically handicapped children who depend on the employee for support.

Component Program(s)	Eligibility
	Effective Date of Dependent Coverage: Dependents are eligible for coverage on the later of (i) the date the Employee is eligible, or (ii) the date the person becomes a Dependent. Termination Date of Dependent Coverage: Coverage ends on the earlier of (i) the date the Employee's coverage terminates, or (ii) the end of the month in which the person ceases to be a Dependent.
Health Savings Accounts (HSAs)	Employees participating in the high deductible health plan option are eligible to receive and make HSA contributions, subject to IRS limits.
Long Term Disability Short Term Disability Group Term Life AD&D	Eligible Employees: All Employees classified by the Employer as benefits eligible employees on the Employer's books and records (generally working 30 or more hours per week), and all Employees classified by the Employer as part-time exempt employees on the Employer's books and records (generally working 20 or more hours per week) are eligible for coverage. Effective Date of Employee Coverage: Employee coverage begins on the date of hire. Termination Date of Employee Coverage: Employee coverage terminates at the end of the month in which termination of employment occurs.
Supplemental Term Life Supplemental AD&D	Eligible Employees: All Employees classified by the Employer as benefits eligible employees on the Employer's books and records (generally working 30 or more hours per week), and all Employees classified by the Employer as part-time exempt employees on the Employer's books and records (generally working 20 or more hours per week) are eligible for coverage. Effective Date of Employee Coverage: Employee coverage begins on the date of hire. Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment. Eligible Dependents: Same as Medical. Effective Date of Dependent Coverage: Same as Medical. Termination Date of Dependent Coverage: Same as Medical.

Component Program(s)	Eligibility
Business Travel and Accident	Eligible Employees: All Employees classified by the Employer as benefits eligible employees on the Employer's books and records (generally working 30 or more hours per week), and all Employees classified by the Employer as part-time exempt employees on the Employer's books and records (generally working 20 or more hours per week) are eligible for coverage. Effective Date of Employee Coverage: Employee coverage begins on the date of hire. Termination Date of Employee Coverage: Employee coverage terminates on the last day of employment.
Employee Assistance Plan (EAP)	Eligible Employees: All Employees classified by the Employer as benefits eligible employees on the Employer's books and records (generally working 30 or more hours per week), and all Employees classified by the Employer as part-time exempt employees on the Employer's books and records (generally working 20 or more hours per week) are eligible for coverage. Effective Date of Employee Coverage: Employee coverage begins on the date of hire. Termination Date of Employee Coverage: Employee coverage terminates at the end of the month in which termination of employment occurs. Eligible Dependents: Same as Medical. Effective Date of Dependent Coverage: Same as Medical. Termination Date of Dependent Coverage: Same as Medical.
Flexible Benefits Plan (Health FSA)	Eligible Employees: All Employees classified by the Employer as benefits eligible employees on the Employer's books and records (generally working 30 or more hours per week), and all Employees classified by the Employer as part-time exempt employees on the Employer's books and records (generally working 20 or more hours per week) are eligible for coverage. Effective Date of Employee Coverage: Employee coverage begins on the date of hire. Termination Date of Employee Coverage: Employee coverage terminates on the date of termination of employment.

Component Program(s)	Eligibility
Prepaid Legal	Eligible Employees: All Employees classified by the Employer as benefits eligible employees on the Employer's books and records (generally working 30 or more hours per week), and all Employees classified by the Employer as part-time exempt employees on the Employer's books and records (generally working 20 or more hours per week) are eligible for coverage. Effective Date of Employee Coverage: Employee coverage begins on the date of hire. Termination Date of Employee Coverage: Employee coverage terminates at the end of the month in which termination of employment occurs.

Please note that coverage begins only upon successful enrollment within the time period specified by the Component Documents. Coverage may also terminate due to nonpayment of premiums, elimination of coverage by the Employer, disenrollment by the Employee, or any other reason permitted under the terms of the applicable Component Documents.

Notwithstanding any other provision of this document to the contrary, to the extent an applicable state law imposes upon this Plan or any Component Document of this Plan a more generous eligibility criteria than that reflected here, such other eligibility criteria will apply to the extent, and only to the extent, required by such applicable law.

AFFILIATED EMPLOYER APPENDIX

(Updated effective January 1, 2024)

Affiliated Employers

None

PLAN SPONSOR ADOPTION PAGE

The undersigned, on behalf of Latitude AI LLC hereby adopts the amended and restated Latitude AI LLC ERISA Wrap Plan & Summary Plan Description, in the form attached hereto, effective as of January 1, 2024.

LATITUDE AI LLC

By: DocuSigned by: Valerie Quatrini 438713DBCBC04B0...

Name: Valerie Quatrini

Title: Director of People Operations

Date: 2/29/2024

HYBRID ENTITY DESIGNATION

A portion of the company's comprehensive health and welfare benefit plan (the "Plan") provides medical care (as defined in section 2791(a)(2) of the Public Health Service Act), and a portion provides other benefits (for example, life insurance, disability, insurance, or similar non-medical care related benefits that, if standing alone as separate plans would not be considered a "health plan" for purposes of the HIPAA Privacy or Security Rules). The Plan hereby makes this hybrid entity designation, under which the non-medical care components of the Plan—the components that, if standing alone, would not be subject to the HIPAA Privacy or Security Rules—are not subject to this Policy nor the HIPAA Privacy or Security Rules.

This designation is effective on the later of (i) the date the HIPAA Privacy Rules would apply to this Plan, and (ii) the date on which the Plan provides both medical care and non-medical care related benefits (as further described above). This designation will remain effective until modified or rescinded.

Latitude AI LLC
"Plan Sponsor"

DocuSigned by:
By Valerie Quartini
438713DBCBC04B0...

Valerie Quartini, Director of People Operations

Date: 3/14/2024