Cigna
Small Group Open Access Plus Plan

Underwritten by
Cigna Health and Life Insurance Company
1-860-226-6000
900 Cottage Grove Road
Bloomfield, CT, 06002

Administered in part by

Mulberry Management
Company

1-855-672-2789
P.O. Box 52146
Phoenix, AZ 85072-2146

Effective Date: October 1, 2020

Certificate

This agreement is governed by the laws of the State of Georgia.

Cigna Health and Life Insurance Company ("Cigna") hereby certifies that it has issued a Health Care and Pharmacy Benefits Contract (herein called the "Plan").

Subject to the provisions of the Plan, each Member, together with his/her eligible Dependents for whom application is initially made and accepted, shall have coverage under the Plan, beginning on the Effective Date shown on the Identification Card, if You make timely payment of total premium due to Cigna. Issuance of this Certificate by Cigna does not waive the eligibility and Effective Date provisions stated in the Plan.

Important Notice of Plan Benefits
Copayment, deductible, and coinsurance options reflect the amount You will pay for Network Provider and Non-Network Provider benefits. Network Provider benefits require use of Network Providers or facilities. We recommend use of Network Providers and facilities, as Member out-of-pocket costs could be lower than when using Non-Network Providers and facilities. Benefits for Emergency Services requiring immediate medical

attention do not require prior authorization or use of Network Providers or facilities. For Emergency Services, a Member has the same Copayment, deductible, and coinsurance requirements, as applicable, at Network and Non-Network Providers.
If you or your Dependents need medical care while away from home, you have access to a national network of Participating Providers. Call the number on your I.D. card for the names of Participating Providers in other network areas.

Cigna has partnered with Oscar Insurance Company and its affiliate, Mulberry Management Corporation ("Oscar"), to provide personalized, technology-driven administrative services in the areas of claims processing, customer service, website tools, and provider information.

In this Plan, "We", "Us" and "Our" means Cigna. As it concerns administrative services performed by Oscar, "We", "Us", and "Our" includes Oscar. "You" are the eligible Subscriber whose enrollment application has been accepted by Us. "You" and "Your" may also refer to any eligible Dependents who are covered under this Plan. The word "Member" means You and any eligible Dependents who are covered under this Plan.

This is Your Certificate for preferred provider organization coverage issued by Cigna. This Certificate, together with the Schedule of Benefits, applications and any amendment or rider amending the terms of this Certificate, constitute the entire agreement between You and Us.

Certificate of Insurance

Premium may be increased upon the Renewal Date of this Certificate; this Certificate may be subject to non- renewal for Dependents surpassing the maximum Dependent age limit. Refer to the **WHO GETS BENEFITS** section of this contract for more information. In the event of a rate increase, We will provide written notice of the increase at least 60 days before the increase takes effect, which will include the dollar amount of the premium before and after the change, and the percentage change between the two.

This Certificate provides benefits for both Network and Non-Network providers. When you select a Network Provider, this Plan pays a greater share of the costs than if you select a Non-Network Provider. When you select a Network Provider, Your cost for medical services provided will be less than when you select a Non-Network Provider. Network Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Network Providers are committed to providing you and your Dependents appropriate care while lowering medical costs. Visit Our website

at www.hioscar.com, or call Us at 1-855-672-2789 to get help finding a Network Provider. A provider listing is available upon request.

Notice: If You or Your Family Members are covered by more than one health care plan, You may not be able to collect benefits from both plans. Each plan may require You to follow its rules or use specific doctors and hospitals, and it may be impossible for You to comply with both plans at the same time. Read all of the rules carefully, including the **COORDINATION OF BENEFITS** section, and compare them with the rules of any other plan that covers You or Your Family.

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INTRODUCTION

Thank You so much for choosing Us! We're so excited to meet You, and look forward to partnering with You towards living Your healthiest life.

We know that health insurance can be confusing. We're committed to making Our plans as simple as possible, because it's really important to Us that You understand:

- How Your Plan works and
- How much You will pay for care.

In this Plan, We will talk to You about a few things:

- The rights and responsibilities that You have, and that We have
- How You can get health care
- What services are covered
- What part of which costs You will need to pay

The benefits provided are intended to assist You with many of Your health care expenses for Medically Necessary services and supplies.

The defined terms in this Plan are capitalized and shown in the appropriate provision in the Plan, or in the **DEFINITIONS** section of the Plan. Whenever these terms are used, the meaning is consistent with the definition given.

Please read this Plan completely and carefully, as many parts are related. Reading just one or two sections may not give You a full understanding of Your coverage. Individuals with special health care needs should read those sections that apply to them carefully.

Important Contact Information

Resource	Contact Information	Accessible Hours
Member Services Helpline	1-855-672-2789	Monday – Friday 8:00 a.m. – 6:00 p.m. (in markets' local time)
Website	www.hioscar.com	24 hours a day 7 days a week
Mailing Address for Oscar	P.O. Box 52146 Phoenix, AZ 85072-2146	24 hours a day 7 days a week
Mailing Address for Cigna	900 Cottage Grove Rd. Bloomfield, CT 06002	24 hours a day 7 days a week
Chat with Your Member Services team	Smartphone app and Member portal at www.hioscar.com	Monday – Friday 8:00 a.m. – 6:00 p.m. (in markets' local time)

Member Services Helpline

Member Services Representatives can:

- Identify Your Service Area
- Give You information about Network and Other Providers contracting with Cigna
- Distribute Claim forms
- Answer Your questions on Claims
- Assist You in identifying a Network Provider
- Provide information on Your Plan features
- Record comments about Providers
- Assist You with questions regarding the **PHARMACY BENEFITS.**

Website

Visit Our website at www.hioscar.com for information about Your coverage, access to forms referenced in this Plan, and much more.

DEFINITIONS

Active status: Means the employee is performing all of his or her customary duties, whether performed at the employer's business establishment, some other location which is usual for the employee's particular duties or another location, when required to travel on the job:

- On a regular full-time basis or for the number of hours per week determined by the policyholder;
- For 48 weeks a year
- Is maintaining a bona fide employer-employee relationship with the policyholder of the group policy on a regular basis.

Each day of a regular vacation and any regular non-working holiday are deemed active status, if the employee was in active status on his or her last regular working day prior to the vacation or holiday. An employee is deemed to be in active status if an absence from work is due to a sickness or bodily injury, provided the individual otherwise meets the definition of employee.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Adverse Determination: Any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service. Adverse Determinations include:

- A determination by Us or Our designee utilization review organization that, based upon the information provided, a request for a benefit under the Plan does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
- The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Us of a Covered person's eligibility to participate in the Plan; or
- Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment for, in whole or in part, a benefit.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how the Allowed Amount is calculated.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: a Grievance concerning Adverse Determinations, including urgent care, concurrent, pre-service or post-service claims.

Authorized Service(s): A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level, subject to any applicable Network Coinsurance, Copayment or Deductible. For more information, see the Claims Payment section.

Balance Billing: When a Non-Network Provider bills You for the difference between the Non-Network Provider's charge and the Allowed Amount. A Network Provider may not Balance Bill You for Covered Services.

Behavioral Health Services: Services or supplies to treat a mental or emotional condition or substance use disorder.

Benefit Period: The length of time that We will pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If Your coverage ends before this length of time, then the Benefit Period also ends.

Benefit Period Maximum: The maximum that We will pay for specific Covered Services during a Benefit Period.

Billed Charges: The amount that a Provider charges for services rendered. Billed Charges may be different from the amount that We determine to be the Allowed Amount for services.

Brand Name Drug: The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

Care Management or Case Management: Programs that promotes cost-effective coordination of care for Members with low-risk health conditions and/or complicated medical needs.

Child (Children): The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the **WHO GETS BENEFITS** section of this Certificate.

Coinsurance: A specific percentage of the Maximum Allowed Amount for Covered Services, that is indicated in the Schedule of Benefits, which You must pay. Coinsurance normally applies after the Deductible that You are required to pay. See the Schedule of Benefits for any exceptions.

Complaint: a verbal expression of dissatisfaction that can often be resolved by an explanation from Us of Our procedures and Your benefit document.

Copay or Copayment: A specific dollar amount of the Maximum Allowed Amount for Covered Services, that is indicated in the Schedule of Benefits, which You must pay. The Copayment does not apply to any Deductible that You are required to pay. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Certificate.

Custodial Service or Care: Care designed to assist You with activities of daily living and which can be provided by a layperson. Custodial Care is not specific treatment for an illness or injury and cannot be expected to substantially improve a medical condition. Such care includes, but is not limited to, eating, bathing, dressing or other self-care activities.

Deductible: The amount You owe before We begin to pay for Covered Services, listed in the Schedule of Benefits. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependent: The Subscriber's spouse or children, who are covered under the Certificate, as described in the **WHO GETS BENEFITS** section.

Diagnostic (Service/Testing): A test or procedure performed on a Member, who is

displaying specific symptoms, to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary Preventive Care screening test that may be required for a Member who is not displaying any symptoms. However, this must be ordered by a Provider.

Domiciliary Care: Care provided in a residential institution, treatment center, halfway house, or school because Your own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Durable Medical Equipment (DME): Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose rather than being used primarily for comfort or convenience, including but not limited to a scooters;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Effective Date: The date that Your coverage begins under this Certificate.

Emergency: A sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses average knowledge of health and medicine could reasonably expect to result in:

- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part; or
- Placing the prudent layperson's health in serious jeopardy.

Emergency Medical Condition: A medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy Serious impairment to such person's bodily functions Serious dysfunction of any bodily organ or part of such person Serious disfigurement of such person.

Emergency Care Services: Those services and supplies that are Medically Necessary

in the treatment of an Emergency and delivered in a Hospital Emergency department.

Employee: Means a person, who is in active status for the employer on a full-time basis. The employee must be paid a salary or wage by the employer that meets the minimum wage requirements of your state or federal minimum wage law for work done at the employer's usual place of business or some other location, which is usual for the employee's particular duties. Employee also includes a sole proprietor, partner or corporate officer, where:

- The employer is a sole proprietorship, partnership or corporation;
- The sole proprietorship or other entity (other than a partnership) has at least one common-law employee (other than the business owner and his or her spouse); and
- The sole proprietor, partner or corporate officer is actively performing activities relating to the business, gains their livelihood from the sole proprietorship, partnership or corporation and is in an active status at the employer's usual place of business or some other location, which is usual for the sole proprietor's, partner's or corporate officer's particular duties.

If specified on the Employer Group Application and approved by us, employee also includes retirees of the employer. A retired employee is not required to be in active status to be eligible for coverage under this policy.

Employer: Means the sponsor of this group insurance plan or any subsidiary or affiliate described in the Employer Group Application. An employer must either employ at least one common-law employee or be a partnership with a bona fide partner who provides services on behalf of the partnership. A business owner and his or her spouse are not considered common-law employees for this purpose if the entity is considered to be wholly owned by one individual or one individual and his or her spouse.

Exclusions: Health care services that We do not pay for or cover.

Experimental/Investigative/Investigational: Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be unproven. For how this is determined, see the **EXCLUSIONS** section.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; Hospice; Home Health Agency or home care services agency certified or licensed under state law; a comprehensive care center for eating disorders pursuant to state law.

Formulary: The list of covered pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

Full-time: For an employee, full-time means a work week of the number of hours determined by the policyholder.

Generic Drugs: Prescription Drugs that have been determined by the Food and Drug Administration (FDA) to be equivalent to Brand Name Drugs, but are not made or sold under a registered trade name or trademark. Generic Drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the Brand Name Drug.

Grievance: a written request for resolution of anything that causes You to be dissatisfied with any aspect of Your relationship with Us, including any request for reversal of an Adverse Determination concerning a claim or authorization for service.

Group: Means the persons for whom this insurance coverage has been arranged to be provided.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitation Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Certificate.

Home Health Agency: An organization currently certified or licensed by the State of Georgia or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to state law or under a similar certification process required by the state in which the hospice organization is located.

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 Us; and
- fulfills any licensing requirements of the state or locality in which it operates.

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, 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.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn’t require an overnight stay.

Identification Card / ID Card: A card issued by Us to You, showing Your name, membership number, and general Plan information.

Inpatient: Care as a registered bed patient in a Hospital or other Facility where a room and board charge is made. This does not apply to a Member who is placed under observation for fewer than 24 hours.

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.

Medically Necessary / Medical Necessity: See the **HOW YOUR PLAN WORKS** section of this Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent who has satisfied the eligibility conditions, applied for coverage been approved by Us and for whom required

Premiums have been paid. Whenever a Member is required to provide a notice pursuant to the terms of this Certificate, "Member" also means the Member's designee.

Network (Participating) Provider

The term Network (Participating) Provider means a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Us to provide covered services with regard to a particular plan under which the participant is covered.

Please visit www.hioscar.com for a list of Network (Participating) Providers and their locations. We can also provide a listing upon request. The list will be revised from time to time by Us.

Non-Network (non-Participating) Provider: A Provider who doesn't have a direct or indirect contractual arrangement with Us to provide services to You.

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."

Other Health Care Facility

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

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is 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.

Out-of-Pocket Limit: The most You pay during a Benefit Period in Cost-Sharing (as listed on Your Schedule of Benefits) before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Outpatient: A Member who receives services or supplies while not an Inpatient.

Pharmacy and Therapeutics (P&T) Committee: A committee consisting of Health Care Professionals, including nurses, pharmacists, and Physicians. The purpose of this committee is to assist in determining clinical appropriateness of Drugs; determining the assignments of Drugs; determining whether a Drug will be included in any of the Formularies; and advising on programs to help improve care. Such programs may include, but are not limited to, Drug utilization programs, preauthorization criteria, therapeutic conversion programs, cross-branded initiatives and Drug profiling initiatives.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his/her 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/she is:

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

Physician Services: Health care services a licensed medical Physician provides or coordinates.

Policy: Means the document, including the Certificate, together with any riders, amendments and endorsements, which describe the agreement between us and the policyholder.

Policyholder: Means the legal entity identified as the policyholder on the face page of the policy who establishes, sponsors and endorses an employee benefit plan for insurance coverage.

Preauthorization or Prior Authorization: The process by which We determine the Medical Necessity of otherwise covered healthcare services prior to the rendering of such healthcare services including, but not limited to, preadmission review, pretreatment review, utilization, and case management. For the purposes of this document, the term "Precertification" is considered to be synonymous with pre-authorization or prior authorization.

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Legend Drug, Prescription Drug, or Drug: A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

Prescription Order: A legal request, written by a Provider, for a Prescription Drug or medication and any subsequent refills.

Primary Care Physician (PCP): A Network Provider who typically is an internal medicine, family practice, general practice, obstetrics/gynecology, geriatrics or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional, Other Health Professional, Facility, or Other Health Care Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, DME, medical supplies, or any other equipment or supplies that are covered under this Certificate that is licensed, registered, certified or accredited as required by state law.

Providers include, but are not limited to, the following persons and facilities listed below. If You have a question about a Provider not shown below, please call the number on the back of Your ID card.

- Alcoholism Treatment Facility - A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.
- Alternative Care Facility – A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI)
    2. Surgery

3. Therapy Services or rehabilitation.

- Ambulatory Surgical Facility - A facility, with an organized staff of Physicians, that:
    1. Is licensed as such, where required;
    2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    3. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    4. Does not provide Inpatient accommodations; and
    5. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.
- Clinical Nurse Specialists whose nursing specialty is Mental Health
- Day Hospital - A facility that provides day rehabilitation services on an Outpatient basis.
- Dialysis Facility - A facility which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at Your home. It is not a Hospital.
- Drug Abuse Treatment Facility - A facility which provides detoxification and/or rehabilitation treatment for drug abuse.
- Home Health Care Agency - A facility, licensed in the state in which it is located, which:
    1. Provides skilled nursing and other services on a visiting basis in the Member's home; and
    2. Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- Home Infusion Facility - A facility which provides a combination of:
    1. Skilled nursing services
    2. Prescription Drugs
    3. Medical supplies and appliances in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.
- Hospice- A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.
- Hospital, as defined.
- Independent Social Workers
- Outpatient Psychiatric Facility - A facility which mainly provides Diagnostic and therapeutic services for the treatment of behavioral health conditions on an Outpatient basis.

- Pharmacy - An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.
- Physician, as defined.
- Professional Clinical Counselors
- Professional Counselors
- Psychiatric Hospital - A facility that, for compensation of its patients, is primarily engaged in providing Diagnostic and therapeutic services for the Inpatient treatment of behavioral health conditions. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- Psychologist, as defined.
- Rehabilitation Hospital - A facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- Retail Health Clinic - A facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.
- Skilled Nursing Facility, as defined.
- Social Worker - A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.
- Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices
- Urgent Care Center, as defined.

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/she is operating within the scope of his/her license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

Referral: An authorization given to one Network Provider from another Network Provider (usually from a PCP to a Network Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider

completing a paper Referral form.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an Inpatient and/or Outpatient setting.

Resident means a person whose domicile is in the state of Georgia. We will require a person to provide proof that his or her domicile is in the state of Georgia.

Schedule of Benefits: A document, incorporated by reference in this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of Georgia, in which We provide coverage. The Service Area is the state of Georgia.

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.

Small employer: Means an employer who employed an average of one but not more than 50 employees on business days during the preceding Plan Year and who employs at least one employee on the first day of the year. All subsidiaries or affiliates of the policyholder are considered one employer when the conditions specified in the "Subsidiaries or Affiliates" section of the policy are met.

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.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

Stabilize: The provision of such medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of an individual's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- 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;
- Serious dysfunction of any bodily organ or part.

In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

Subcontractor: An organization or entity that has specialized expertise in certain areas to whom we may subcontract particular services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or Member Services duties on Our behalf.

Subscriber: The person to whom this Certificate is issued.

Telehealth means the use of information and communications technologies, including, but not limited to, telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health related education, public health, and health administration.

Telemedicine means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in this state, while such patient is at an originating site and the health care provider is at a distant site.

Therapy Services: Services and supplies that are used to help a person recover from an illness or injury. Covered Therapy Services are limited to services listed as Covered Services in this Certificate.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what Providers in the area usually charge or accept for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Physician’s office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

HOW YOUR PLAN WORKS

Cigna Open Access Plus Provisions

Network

The Network for this Plan is the Open Access Plus Network. The Open Access Plus Network has been specially designed to contain the best Providers that we're confident will serve all of Your needs. You can access up-to date lists of Our Network Providers and other Open Access Plus Network information at www.hioscar.com. Printed directories are available upon request, without charge.

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 Us 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.

Specialists

A wide range of Specialists are included in the Open Access PlusNetwork.

There may be occasions when the services you require are not available from Network Providers. If You have a complex medical problem that cannot be taken care of by a Network Provider, Network Benefits may be provided when You a use a Non-Network Provider. Contact Us at 1-855-672-2789 to receive the necessary Prior Authorization for Out-of-Network services in this situation.

Emergency Services and Care Outside of the Service Area

A Member who is temporarily outside of the Service Area; who immediately needs Medically Necessary services, the condition for which the services are required could not have been foreseen; whose medical condition does not permit him/her to return to the Service Area for treatment; and who was outside of the Service Area for some purpose other than the receipt of treatment for a medically-related condition may go to a Network Provider or an Out-of-Network Provider. We will provide benefits for this care, if received from an Out-of-Network Provider, to the same extent as would

have been provided if care and treatment were provided by a Network Provider. We will provide benefits for this care until the Member's medical condition permits travel or transport to Our Service Area. If a Member receives care and treatment for an Emergency from an Out-of-Network Provider, You should notify Us as soon as reasonably possible.

We do not provide coverage for Out-of-Area Services for anything other than Emergency Services as outlined above.

Network Providers

To receive In-Network Benefits as indicated on Your Schedule of Benefits, You must choose Providers within the Network for all care (other than for Emergency Services). The Open Access Plus Network consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Members throughout the Service Area. Refer to Your Provider Directory or visit Our website at www.hioscar.com to make Your selections. The list of Network Provider may change occasionally, so make sure the Providers You select are still Network Providers at the time of service. An updated directory will be available at least annually or You may access Our website at www.hioscar.com for the most current listing to assist You in locating a Provider. Our Member Services team is available to assist You in finding the Network Provider that will best suit Your needs at 1-855-672-2789, through Our mobile application, or on Our Member portal at www.hioscar.com.

This Certificate has two levels of benefits. By using Network Providers, You receive the benefit of plan coverage at the lowest cost. You can also choose to use Providers that are not Network Providers. These are called Non-Network Providers.

If You choose a Network Provider, the Provider will bill Us – not You – for services provided. The Provider has agreed to accept as payment in full:

- The billed charges, or
- The Allowed Amount as determined by Us, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles, Copayment Amounts, and Coinsurance Amounts as set forth in Your Schedule of Benefits. No Claim forms are required. A Network Provider is not permitted to bill You for anything other than your Copayment, Coinsurance, Deductible for Medically Necessary Covered Services.

No payment will be made by Us for services which are not covered, and coinsurance will not apply to charges for such services. To the extent any refunds, rebates or any other form of negotiated post-payment adjustment takes place, it will

not reduce your coinsurance amount.

To find out if a Provider is a Network Provider:

- Check Your Provider directory, available at Your request;
- Call 1-855-672-2789; or
- Visit Our website at www.hioscar.com.

Non-Network Providers

You may elect to see a Non-Network Provider. However, please note some services require prior authorization, and your costs will be higher if you receive care from a Non-Network Provider. Please refer to Your Schedule of Benefits for more information.

You may also be Balance Billed by the Non-Network Provider for the difference between the Non-Network Provider's charge and the Allowed Amount.

When You visit an Non-Network Provider for pre-authorized services not available from a Network Provider, We will:

- pay the Claim at the Usual, Customary, and Reasonable rate for the service, less any patient Coinsurance, Copayment, or Deductible responsibility under the Plan;
- pay the Claim at the preferred benefit cost-sharing level; and when issuing payment, provide You with an explanation of benefits.

If You obtained Prior Authorization for Non-Network Services due to an access issue, We will cover the Covered Services at no greater cost to You than if the Covered Services were obtained from a Network Provider.

Covered Services.

You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary or otherwise specifically included as a Covered Service under this Certificate;
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Certificate is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Certificate, or by any amendment or rider thereto; and
- Authorized in advance by Us if such Preauthorization is required in this Certificate.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to You. The incurred date (for determining application of Deductible

and other Cost-Sharing) for an Inpatient admission is the date of admission except as otherwise specified in benefits after termination. Covered Services do not include any services or supplies that are not documented in Provider records.

When You are outside Our Service Area, coverage is limited to Emergency Services, Pre- Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

Access to OB/GYN Care.
You do not need Preauthorization from Us or from any other person (including a PCP) 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 Preauthorization for certain services or following a pre-approved treatment plan. For a list of Network Health Care Professionals who specialize in obstetrics or gynecology, contact the phone number on Your ID Card or visit Our website at www.hioscar.com.

Preauthorization

Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the services listed in Your Schedule of Benefits that require Preauthorization.

Services Subject to Preauthorization

If You require a Medically Necessary Covered Service that is not available through a Network Provider and We authorized Your Network Provider's Referral, We will cover the service from the Non-Network Provider as if it were performed by a Network Provider.
We will reduce benefits by 50% with respect to charges for treatment, services and supplies for services which require prior authorization by us but for which You or Your Provider did not request prior authorization.

Prior Authorization/Notification Procedure
If You seek coverage for services that require Preauthorization or notification, You or Your Provider must call Us at the number on Your ID card.
You or Your Provider must contact Us to request Preauthorization as follows:

- At least five (5) days prior to an elective admission as an inpatient in a hospital, extended care or rehabilitation facility, or hospice facility
- At least thirty (30) days prior to the initial evaluation for organ transplant services
- At least thirty (30) days prior to receiving clinical trial services
- At least five (5) days prior to a scheduled inpatient behavioral health or substance

abuse treatment admission
- At least five (5) days prior to the start of home healthcare services

You must contact Us to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If You are hospitalized in cases of an Emergency Condition, You must call Us within 24 hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical Certificate, clinical guidelines, and pharmacy and therapeutic guidelines.

Utilization review

Utilization review means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures, or settings. Areas of review may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

Your Plan includes the processes of Pre-Service, Concurrent and Retrospective Reviews to determine when services should be covered by Your Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Your Plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

Prior Authorization.

Providers are responsible for obtaining Prior Authorization when required for You to receive benefits. Prior Authorization criteria will be based on multiple sources including medical Certificate, clinical guidelines, and pharmacy and therapeutics guidelines. We may determine that a service that was initially prescribed or requested is not Medically Necessary if You have not previously tried alternative treatments which are more cost effective.

Prior Authorization requests must be received by phone, fax, in writing or through a secure online portal as follows:

- At least 5 days prior to an elective admission as an inpatient in a Hospital, extended care or Rehabilitation facility, or Hospice facility.
- At least 30 days prior to the initial evaluation for organ transplant services.
- At least 30 days prior to receiving clinical trial services.

- At least 5 days prior to a scheduled inpatient behavioral health or Substance Abuse treatment admission.
- At least 5 days prior to the start of Home Health Care.

If You have any questions regarding the information contained in this section, You may call Us at telephone number on Your Identification Card or visit www.hioscar.com.

Types of Requests.

Precertification

A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, You, Your authorized representative or Physician must notify Us within 24 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is preferred but not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Medical Review

A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification. Medical Reviews occur for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Request Categories.

Urgent

A request for Precertification that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the member to severe pain that cannot be adequately managed without such care or treatment.

If an urgent care review request is not approved, the Member may proceed with an expedited independent review while simultaneously pursuing an Appeal through Our Appeal process.

Prospective

A request for Precertification that is conducted prior to the service, treatment or admission.

Concurrent

A request for Precertification that is conducted during the course of treatment or admission. If a concurrent review request is not approved, a Member who is receiving an ongoing course of treatment may proceed with an expedited independent review while simultaneously pursuing an Appeal through Our Appeal process.

Retrospective
A request for Precertification that is conducted after the service, treatment or admission has occurred. Medical Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements.
Timeframes and requirements listed are based on state and federal regulations. Where state regulations are stricter than federal regulations, We will abide by state regulations. If You reside and/or receive services in a state other than the state where Your contract was issued, other state-specific requirements may apply. You may call Us at the telephone number on Your ID Card for more information.

Request Category	Timeframe
Prospective Urgent	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non-Urgent	72 hours or 2 business days from the receipt of request whichever is less
Concurrent Urgent (when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists)	24 hours or 1 business day from the receipt of the request whichever is less
Concurrent Urgent (when request is received more than 24 hours after the expiration of the previous authorization or no previous authorization exists)	72 hours or 2 business days from the receipt of request whichever is less
Concurrent Non-Urgent	72 hours or 1 business day from the receipt of the request whichever is less

Retrospective	30 calendar days from the receipt of the request

If additional information is needed to make Our decision, We will notify the requesting Provider and send written notification to You or Your authorized representative of the specific information necessary to complete the review. If We do not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in Our possession.

We will provide notification of Our decision in accordance with state and federal regulations. Notification may be given by the following methods:

- Verbal: oral notification given to the requesting Provider via telephone or via electronic means if agreed to by the Provider.
- Written: mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and the Member or authorized Member representative.

Pharmacy Benefits

Benefits are provided for those Covered Drugs as explained in the **PHARMACY BENEFITS** section and shown on Your Schedule of Benefits. The amount of Your payment under the Plan depends on whether:

- the Prescription Order is filled at a Participating Pharmacy or through the Mail-Order Program; or
- the Prescription Order is filled by a Provider contracting with Cigna; or
- the formulary tier the drug is placed on; or
- a Generic Drug is dispensed; or
- a Preferred or Non-Preferred Brand Name Drug is dispensed; or
- a Specialty Drug is dispensed.

Case Management

Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet

program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.
In certain cases of severe or chronic illness or Injury, We may provide benefits for alternate care through Our case management program that is not a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Plan. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us. Nothing in this provision shall prevent You from Appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

Medical Necessity
All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by Us. Charges for services and supplies which We determine are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Maximum Out of Pocket amount.

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and

duration, and considered effective for Your illness, injury, or disease;

- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not Experimental/Investigative nor subject to an Exclusion under this Certificate;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an Outpatient basis or an infusion or injection of a specialty drug provided in the Outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

See the **COMPLAINTS & GRIEVANCES** section of this Certificate for Your right to an Appeal and independent review of Our determination that a service is not Medically Necessary.

Identification Card

The Identification Card tells Providers that You are Entitled to benefits under Your Health Benefit Plan with Us. The ID Card offers a convenient way of providing important information specific to Your coverage including, but not limited to, the following:

- Your Member ID.
- Any Cost-Sharing Amounts that may apply to Your coverage.
- Important telephone numbers.

Always remember to carry Your Identification Card with You and present it to Your Providers or In-Network Pharmacies when receiving health care services or supplies. Please remember that any time a change in Your family takes place, issuance of a new ID Card may be necessary. Upon receipt of the change in information, We will provide a new ID Card.

Medical Management

The benefits available to You under this Certificate are subject to pre- service, concurrent and retrospective reviews to determine when services should be Covered

by Us. The purpose of these reviews is to promote the delivery of cost- effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

Claims Provisions

When You or Your Covered Dependent(s) receive Covered Services from a Network Provider, the Provider will submit a claim to Us. If You receive Covered Services from aNon-Network Provider, either You or the Provider must submit a claim form to Us. If You receive Covered Services from a Non-Network Pharmacy, You must submit a claim form to Us. We will review the claim and let You or the Provider know if We need more information before We pay or deny the claim. We follow Our internal administration procedures when We process claims.

A claim must be filed for You to receive Non-Network Services benefits, but many Non-Network Hospitals, Physicians and other Providers will still submit Your claim for You. If You submit the claim, use a claim form.

Notice of Claim

We are not liable under the Certificate, unless We receive written notice that Covered Services have been given to You. The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for Your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given. If We are unable to complete processing of a claim because You or Your Provider fail to provide Us with the additional information within 60 days of Our request, the claim will be denied. We will reopen and process the claim if You or Your Provider submit additional information within the timeframes specified below.

Failure to give Us notice within 90 days will not reduce any benefit if You show that

the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid except in the case of fraud by a Provider.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for claim forms to Us, or contact Member Services and ask for claim forms to be sent to You. If You do not receive the claim forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim.

This includes:

- Name of patient.
- Patient's relationship with the Subscriber.
- Identification number.
- Date, type and place of service.
- Your signature and the Provider's signature.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program.

Explanation of Benefits (EOB)

After You receive medical care, You will receive an explanation of benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement from Us to help You understand the coverage You are receiving. The EOB shows:

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by Your coverage.
- The amount for which You are responsible (if any).
- General information about Your Appeal rights.

Termination

Termination of Insurance

The date of termination, as described in this "Termination Provisions" section, may be the actual date specified or the end of that month, as selected by your employer on the Employer Group Application (EGA).

You and your employer must notify us as soon as possible if you or your dependent no longer meets the eligibility requirements of the policy. Notice must be provided to us within 31 days of the change.

When we receive notification of a change in eligibility status in advance of the effective date of the change, insurance will terminate on the actual date specified by the employer or employee or at the end of that month, as selected by your employer on the EGA.

When we receive the employer's request to terminate coverage retroactively, the employer's termination request is their representation to us that you did not pay any premium or make contribution for coverage past the requested termination date.

- Otherwise, insurance terminates on the earliest of the following:
    - The date the group policy terminates;
    - The end of the period for which required premium was paid to us;
    - The date the employee terminated employment with the employer;
    - The date the employee is no longer qualified as an employee;
    - The date you fail to be in an eligible class of persons as stated in the EGA;
    - The date the employee entered full-time military, naval or air service;
    - The date the employee retired;
    - The date of an employee request for termination of insurance for the employee or dependents;
    - For a dependent, the date the employee's insurance terminates;
    - The date your dependent no longer qualifies as a dependent;
    - For a dependent, the date the employee ceases to be in a class of employees eligible for dependent insurance;
    - For any benefit, the date the benefit is deleted from the policy; or
    - The date fraud or an intentional misrepresentation of a material fact has been committed by you. For more information on fraud and intentional misrepresentation, refer to the "Fraud" provision in the "Miscellaneous Provisions" section of this certificate.

Termination for Cause

We will terminate your coverage for cause under the following circumstances:

- If you or the policyholder perpetrate fraud or intentional misrepresentation on claims, identification cards or other identification in order to obtain services or a higher level of benefits. This includes, but is not limited to, the fabrication or alteration of a claim, identification card or other identification.
- If you allow an unauthorized person to use your identification card or if you use the identification card of another covered person. Under these circumstances, the person who receives the services provided by use of the identification card will be responsible for paying us the maximum allowable fee for those services.

Reinstatement

For coverage that is not purchased through the Exchange, if any renewal Premium be not paid within the time granted the insured for payment, a subsequent acceptance of Premium by the insurer or by any agent duly authorized by the insurer to accept such Premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Plan: Provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the Premium tendered, the Plan will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. Reinstatement requests must be received within 60 days of the last date of coverage with the Plan, and not to exceed 2 requests for reinstatement per coverage year. The reinstated Plan shall cover only loss due to such Sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the Plan immediately before the due date of the defaulted Premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement.

Refunds

When a Member's coverage is terminated any periodic payments received on account of the terminated Member applicable to periods after the Effective Date of termination, less any amounts due to Us or Network Providers for coverage and/or Covered Services provided prior to the date of termination, shall be refunded or credited to the Subscriber within 31 days. Neither We nor Network Providers shall have any further liability under this Plan.

Health Status

Members enrolled under this Certificate will not have coverage terminated because of health status, or the need for Medically Necessary Covered Services.

Unpaid Premium
Any unpaid Premium may be sent to collections for recovery. We may retroactively terminate and refund a maximum of one month's Premium when You provide proof of overlapping coverage. If You had Claims during that month, We will not provide a Premium refund. You will be responsible for any Claims filed after the retroactive termination. Upon the payment of a claim under this Certificate, any premium then due and unpaid or covered by any note or written order may be deducted therefrom

Continuity of Care
You are allowed to continue treatment with a Provider whose contract has been terminated by Us for reasons other than for cause, or a Provider who has terminated his/her contract with Us, for a transitional period of up to 90 days from the date of Provider termination when the continuation of care is Medically Necessary and meets certain conditions, as outlined in Our Georgia Continuity of Care policy. You will not be liable to the Provider for any amounts owed for medical care other than Deductibles, Coinsurance, or Copayment amounts specified in this Certificate.

Continuation Of Coverage

Continuation Options in the Event of Termination
If health insurance terminates:

- It may be continued as described in the "State continuation of health insurance" provision;
- It may be continued as described in the "Continuation of coverage for dependents" provision, if applicable; or
- It may be continued under the continuation provisions as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA), if applicable.

A complete description of the "State continuation of health insurance" and "Continuation of coverage for dependents" provisions follows.

State Continuation of Health Insurance
A covered person whose coverage terminates shall have the right to continuation under the policy as follows.

An employee may elect to continue coverage for himself or herself.

If an employee was insured for dependent coverage when his or her health insurance

terminated, an employee may choose to continue health insurance for any dependent who was insured by the policy. The same terms with regard to the availability of continued health insurance described below will apply to dependents.

In order to be eligible for this option:

- The employee must have been continuously covered under the policy or the policy it replaced for at least three consecutive months prior to termination; and
- The covered person's coverage must be terminated for any other reason, except discontinuance of the policy in its entirety or with respect to an insured class.

There is no right to continuation if:

- The termination of coverage occurred because the employee failed to pay the required premium contribution;
- The discontinued group coverage was replaced by similar group coverage within 31days of the discontinuance; or
- The covered person is or could be covered by Medicare.

Written application and payment of the first premium for continuation must be made within 31 days after the date coverage terminates or within 31 days after the covered person has been given any required notice. No evidence of insurability is required to obtain continuation.

Each covered person may choose to continue these benefits for up to maximum of three months plus the fraction of the month remaining, unless coverage is terminated during pregnancy. Continuation will be permitted for the term of the pregnancy including the fraction of the month remaining at the time of termination plus an additional six months after the pregnancy ends.

If coverage ends due to death of or divorce from the primary insured, Continuation will be permitted for fifteen months.

The premium rate will be 100% of the group premium. The premium will be payable in advance to the policyholder on a monthly basis.

Continuation may not terminate until the earliest of:

- The time period, as referenced above, after the date the employee was no longer eligible for coverage;
- The date timely premium payments are not made on your behalf;
- The date the group coverage terminates in its entirety;
- The date on which the covered person is, or could be, covered under Medicare;
- The date on which the covered person is covered for similar benefits under another group or individual policy;
- The date on which the covered person is eligible for similar benefits under another group plan; or
- The date on which similar benefits are provided for, or available to, the covered person under any state or federal law.

The policyholder is responsible for sending us the premium payments for those individuals who choose to continue their health insurance.

Continuation of Coverage for Dependents.
Continuation of coverage is available for dependents whose coverage under the policy has been terminated for any reason, except discontinuance of the policy in its entirety.

Each dependent may choose to continue these benefits for a maximum of three months plus the fraction of the month remaining, unless:

- Coverage is terminated during the dependent's pregnancy. Continuation will be permitted for the term of the pregnancy including the fraction of the month remaining at the time of termination plus an additional six months after the pregnancy ends.
- The policy terminates because of divorce or death of the employee while dependent coverage is in force. The surviving dependent spouse and dependent children may continue to be insured for a period of 15 months plus the fraction of the month remaining at the time of termination.

Written application and payment of the first premium for continuation must be made within 31 days after the date coverage terminates or within 31 days after the covered person has been given the required notice. No evidence of insurability is required to obtain continuation.

- The covered employee or dependent must give the policyholder written notice

within 30 days of any severance of the family relationship that might activate this continuation option; and

- The policyholder must give written notice to each affected dependent of the continuation option immediately upon receipt of notice of severance of the family relationship or upon receipt of notice of the employee's death or retirement; and
- The dependent must give written notice to the policyholder of his or her desire to exercise the continuation option within 30 days from the date of severance of the family relationship or the date of the employee's death or retirement.

The policyholder must notify us of the choice to continue coverage upon receipt of it.

The option to continue coverage is not available if:

- The policy terminates;
- The dependent was not continuously covered under the policy and the Prior Plan replaced by the policy for at least three consecutive months prior to the date coverage terminates, except in the case of an infant under one year of age; or
- The dependent elects to continue his or her coverage under the terms and conditions described in (COBRA).

Continued coverage terminates on the earliest of the following dates:

- The time period, as referenced above, after the date the dependent was no longer eligible for coverage;
- The date the dependent becomes eligible for similar group benefits, either on an insured or self-insured basis;
- The date timely premium payments are not made on your behalf; or
- The date the policy terminates.

The premium rate will be 100% of the group premium. The premium will be payable in advance to the policyholder on a monthly basis.

The policyholder is responsible for sending us the premium payments for those individuals who choose to continue their health insurance. If the policyholder fails to make proper payment of the premiums to us, we are relieved of all liability for any health insurance that was continued and the liability will rest with the policyholder.

MEDICAL BENEFITS EXTENSION UPON POLICY CANCELLATION

If the medical benefits under this Plan cease for You or your Dependent due to cancellation of the Policy, and You or Your Dependent is Totally Disabled on that date due to an injury or sickness, medical benefits will be paid for covered expenses. However, no benefits will be paid after the earliest of:

- the date you exceed the maximum benefit, if any, shown in the Schedule of Benefits;
- the date you are no longer totally disabled;
- 12 months from the date your medical benefits cease; or
- 12 months from the date the policy is canceled.

Totally Disabled

You will be considered totally disabled if, because of an injury or a sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered totally disabled if, because of an injury or a sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

WHO GETS BENEFITS

Eligibility Date

Employee Eligibility Date

The employee is eligible for coverage on the date:

- The eligibility requirements are satisfied as stated in the Employer Group Application, or as otherwise agreed to by the policyholder and us; and
- The employee is in an active status.

Dependent Eligibility Date

Each dependent is eligible for coverage on:

- The date the employee is eligible for coverage, if he or she has dependents who may be covered on that date;
- The first of the month following the date of the employee's marriage, for any dependents (spouse or child) acquired on that date;
- The date of birth of the employee's natural-born child;
- The date of adoption for an employee's adopted child, or the date of placement of the child for the purpose of adoption by the employee; or
- The date specified in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) for a child, or a valid court or administrative order for a spouse, which requires the employee to provide coverage for a child or spouse as specified in such orders.

The employee may cover his or her dependents only if the employee is also covered.

A child dependent will continue to be eligible for coverage until the end of the month in which the child turns age 26 unless, the dependent child is: incapable of self-sustaining employment by reason of intellectual or physical disability; and is chiefly dependent upon the insured for support and maintenance, provided that proof of such is furnished to Us within 31 days of the date on which the dependent child would otherwise become ineligible for coverage.

After an initial two-year period following the date on which the disabled dependent child attained the limiting age, the insurer may require proof annually of the child's continued incapacity and dependency. If you have a disabled dependent, please call Us at (855) 672-2784 to request a disabled dependent form).

Enrollment

Employees and dependents eligible for coverage under the policy may enroll for coverage as specified in the enrollment provisions outlined below.

Employee Enrollment
The employee must enroll, as agreed to by the policyholder and us, within 31 days of the employee's eligibility date or within the time period specified in the "Special enrollment" provision.

The employee is a late applicant if enrollment is requested more than 31 days after the employee's eligibility date or later than the time period specified in the "Special enrollment" provision. A late applicant must wait to enroll for coverage during the open enrollment period, unless the late applicant becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Health status will not be used to determine premium rates. We will not use health status-related factors to decline coverage to an eligible employee and we will administer this provision in a non-discriminatory manner.

Dependent Enrollment
If electing dependent coverage, the employee must enroll eligible dependents, as agreed to by the policyholder and us, within 31 days of the dependent's eligibility date or within the time period specified in the "Special enrollment" provision.

The dependent is a late applicant if enrollment is requested more than 31 days after the dependent's eligibility date or later than the time period specified in the "Special enrollment" provision. A late applicant must wait to enroll for coverage during the open enrollment period, unless the late applicant becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Health status will not be used to determine premium rates. We will not use health status-related factors to decline coverage to an eligible dependent and we will administer this provision in a non-discriminatory manner.

Newborn and Adopted Dependent Enrollment
A newborn dependent will be covered from the date of birth to 31 days of age. An adopted dependent will be automatically covered from the date of adoption or

placement of the child with the employee for the purpose of adoption, whichever occurs first, for 31 day

If additional premium is not required to add additional dependents and if dependent child coverage is in force as of the newborn's date of birth in the case of newborn dependents or the earlier of the date of adoption or placement of the child with the employee for purposes of adoption in case of adopted dependents, coverage will continue beyond the initial 31 days. You must notify us to make sure we have accurate records to administer benefits.

If premium is required to add dependents you must enroll the dependent child and pay the additional premium within 31 days:

- Of the newborn's date of birth; or
  Of the date of adoption or placement of the child with the employee for the purpose of adoption to add the child to your plan, whichever occurs first.

If enrollment is requested more than 31 days after the date of birth, or date of adoption or placement with the employee for the purpose of adoption, and additional premium is required, the dependent is a late applicant. A late applicant must wait to enroll for coverage during the open enrollment period, unless the late applicant becomes eligible for special enrollment as specified in the "Special enrollment" provision.

Special Enrollment Periods
If You experience a Triggering Event, You may qualify for a Special Enrollment Period, during which You can enroll for coverage and enroll Your eligible Dependent(s), instead of waiting for the next Annual Open Enrollment Period.

Triggering Events for a Special Enrollment Period can be categorized into the following groups:

- Loss of qualifying health coverage;
- Change in household size;
- Change in primary place of living;
- Change in eligibility for Exchange coverage or help paying for coverage;
- Enrollment or plan error;
- Other qualifying changes.

Note that failure to pay premiums, or coverage that is lost on the basis of fraud or an intentional misrepresentation of material fact is never a triggering event.

"Loss of qualifying health coverage" includes:

- You or Your dependent has lost minimum essential coverage during or at the end of the coverage year, including but not limited to Medicaid, CHIP, qualifying employer sponsored coverage
- It is the end of the Plan Year for Your non-Plan Year employer-sponsored coverage;
- Your COBRA coverage has been exhausted;
- You are no longer eligible to be covered as a dependent due to reaching the limiting age;
- You or Your dependent loses employer-sponsored health plan coverage because of voluntary or involuntary termination of employment or a reduction in work hours, for reasons other than misconduct; or
- You, Your spouse or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, or death of the covered employee.

"Change in household size" includes:

- You gain a dependent or become a dependent through marriage;
  - Note that one spouse must have had minimum essential coverage for one or more days in the 60 days prior to the marriage, unless that spouse was living in a foreign country or US territory, or is a member of a federally recognized tribe or a shareholder in an Alaska Native Corporation.
- You gain a dependent or become a dependent through birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order;
- You lose a dependent due to divorce, legal separation, or death.

"Change in primary place of living" includes:

- You or Your dependent gain access to new plans as a result of a permanent move.
  - Note that You or Your dependent must have had minimum essential coverage for one or more days in the 60 days prior to the marriage, unless You or Your dependent were living in a foreign country or US territory, or is a member of a federally recognized tribe or a shareholder in an Alaska Native Corporation.

- Moving solely for medical treatment or vacation are not valid Triggering Events.

"Change in eligibility for Exchange coverage or help paying for coverage" includes:

- You or Your dependent are determined newly eligible or newly ineligible for advance payments of the premium tax credit (APTC) or has a change in eligibility for cost-sharing reductions (CSR);

"Enrollment or plan error" includes:

- You or Your dependent's enrollment or non-enrollment in a Plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee or agent of the Exchange, or of the Department of Health and Human Services (HHS), its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities;
- You or Your dependent's enrollment or non-enrollment in a Plan or inaccurate eligibility determination is a result of a technical error;
- You or Your dependent adequately demonstrate to the Exchange or State Regulatory Agency, that the plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrolle;
- You or Your dependent applied for coverage through the Exchange either during the annual open enrollment period or due to a qualifying event or at the State Medicaid or CHIP agency during the annual open enrollment period, and are determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after Open Enrollment has ended or more than 60 days after the qualifying event.

"Other qualifying changes" includes:

- You or Your dependent are survivors of domestic abuse or spousal abandonment;

Triggering Events do not include loss of coverage due to failure to make Premium payments on a timely basis. This includes COBRA Premiums prior to the expiration of Your COBRA coverage and situations allowing for a rescission as specified under federal and state law.

Special Enrollment Periods begin on the date the Triggering Event occurs, and end on the 61st day afterwards. Note that for "Loss of qualifying health coverage" and "Change in primary place of living" categories of Triggering Event, you may also submit an application in the 60 days leading up to the event. Persons who enroll during a Special Enrollment Period will have their coverage Effective Dates

determined as follows:

- In the case of birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order, Your coverage is effective on the date the event;
- In the case of marriage, or in the case where You lose minimum essential coverage, coverage is effective on the first day of the following month.
- In the case where the application is submitted before the event, coverage is effective the first day of the month following the event.

In all other cases, the Effective Dates are as follows:

- For an application made between the first and the 15th day of any month, the Effective Date of coverage will be the first day of the following month; or
- For an application made between the 16th and the last day of the month, the Effective Date of coverage will be the first day of the second following month.

Open Enrollment

Eligible employees or dependents, who do not enroll for coverage under the policy following their eligibility date or special enrollment date, have an opportunity to enroll for coverage during the open enrollment period. The open enrollment period is also the opportunity for late applicants to enroll for coverage.

Eligible employees or dependents, including late applicants, must request enrollment during the open enrollment period. If enrollment is requested after the open enrollment period, the employee or dependent must wait to enroll for coverage during the next open enrollment period, unless they become eligible for special enrollment as specified in the "Special enrollment" provision.

Effective Date.

The provisions below specify the effective date of coverage for employees or dependents if enrollment is requested within 31 days of their eligibility date or within the time period specified in the "Special enrollment" provision. If enrollment is requested during an open enrollment period, the effective date of coverage is specified in the "Open enrollment effective date" provision.

Employee Effective Date

The employee's effective date provision is stated in the Employer Group Application. The employee's effective date of coverage may be the date immediately following completion of the waiting period, or the first of the month following completion of the waiting period, if enrollment is requested within 31 days of the employee's eligibility date. In any case, a waiting period will not exceed 90 days. The special enrollment

date is the effective date of coverage for an employee who requests enrollment within the time period specified in the "Special enrollment" provision. The employee effective dates specified in this provision apply to an employee who is not a late applicant.

Dependent Effective Date
The dependent's effective date is the date the dependent is eligible for coverage if enrollment is requested within 31 days of the dependent's eligibility date. The special enrollment date is the effective date of coverage for the dependent who requests enrollment within the time period specified in the "Special enrollment" provision. The dependent effective dates specified in this provision apply to a dependent who is not a late applicant.

In no event will the dependent's effective date of coverage be prior to the employee's effective date of coverage.

Newborn and Adopted Dependent Effective Date
The effective date of coverage for a newborn dependent is the date of birth the newborn is not a late applicant.

The effective date of coverage for an adopted dependent is the date of adoption or the date of placement with the employee for the purpose of adoption, whichever occurs first, if the dependent child is not a late applicant.

Premium is due for any period of dependent coverage whether or not the dependent is subsequently enrolled, unless specifically not allowed by applicable law. Additional premium may not be required when dependent coverage is already in force.

Open Enrollment Effective Date
The effective date of coverage for an employee or dependent, including a late applicant, who requests enrollment during an open enrollment period, is the first day of the policy year as agreed to by the policyholder and us.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS AND BENEFITS

Deductible
Except where stated otherwise, You must pay the amount in the Schedule of Benefits for Covered Services during each Benefit Period before We provide coverage. If You have other than individual coverage, there is an individual Deductible which applies to

each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Benefit Period. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount in the Schedule of Benefits in a Benefit Period, no further Deductible will be required for any person covered under this Certificate for that Benefit Period. The Deductible runs from the Effective Date through a 12-month period following the Effective Date (the "Plan Year").

Copayments

Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

Coinsurance

Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits. Your Coinsurance does not apply to charges for services which are not covered and will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Out-of-Pocket Limit

When You have met Your Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Benefit Period in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Benefit Period. If You have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Limit in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for the rest of that Benefit Period for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family Out- of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Benefit

Period in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for the rest of that Benefit Period for the entire family.

Allowed Amount.

The Allowed Amount means the maximum amount We will pay for the services or supplies Covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Network Providers will be the amount We have negotiated with the Network Provider or the Network Provider's charge.
See the Emergency Services section of this Certificate for the Allowed Amount for an Emergency Condition.

The Allowed Amount for covered services provided by a Non-Network Provider is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- a percentage (110%) of a fee schedule We have 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.

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

- the provider's normal charge for a similar service or supply; or
- the 70th 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 Us. If sufficient charge data is unavailable in the database for that geographic area to determine the Allowed Amount, then data in the database for similar services may be used.
- 50% of the provider's normal charge (i.e., the charge made to patients without coverage) for a similar service or supply

The Allowed Amount is subject to all other benefit limitations and applicable coding and payment methodologies determined by Us. Additional information about how We determine the Allowed Amount is available upon request.

Payment of Premiums

Payment of monthly Premiums for coverage under this Certificate shall be made by the Subscriber. Premiums shall be remitted on a monthly basis to Us within the specified time frames set forth in this Certificate. Only a Member for whom the Premium is actually received by Us, who has met all other applicable provisions of this Certificate, and who has been accepted by Us, shall be entitled to coverage under this Certificate and only for the month for which such Premium is received except with respect to Newborn coverage, which is automatically provided under this Certificate for the first 31 days.

Adjustment of Premiums

The monthly Premiums shall be effective until notification of adjustment to Premiums is provided by Us to the Subscriber. We will notify the Subscriber at the last address known to Us, of any adjustment to Premiums, not less than 60 days prior to the Effective

Date of such rate change, or as permitted by law.

Time of Payment

The first monthly Premium must be paid no later than 30 calendar days from the coverage Effective Date of the Certificate, and succeeding Premiums must be paid on or before the first day of each succeeding month in order for benefits to be provided, subject to the grace period provisions specified under this Certificate.

COVERED SERVICES

This Certificate lays out the Covered Services that You are entitled to receive by being a part of the Plan. It also tells You what exclusions, conditions, and limitations You'll be subject to. The Covered Services You receive need to be Medically Necessary, and a Provider needs to be the one billing Us for them. You can look at Your Schedule of Benefits to see the payments we'll ask You to make for these Covered Services.

The benefits listed as Covered in this section are subject to the Deductible, Copayment or Coinsurance, and Maximum Out-of-Pocket limit that are shown on Your Schedule of Benefits. However, Preventive Services are not subject to the Deductible, Copayment, or Coinsurance.

How a Covered Service may be obtained, Coverage Limits and Member's Cost Sharing obligations:
The following Sections sets forth how You may obtain a Covered Service, what Covered Services You're able to receive, where You can get Covered Services, and second opinion coverage.

We encourage You to call the telephone number on the back of Your Identification Card if there are questions relating to the coverage of Covered Services set forth in this Section, Member's Cost Sharing or how the Covered Service may be obtained by You.

Covered Services from a Network or Non-Network Provider

Our Coverage of Covered Services
Just because Your Physician or any other Provider may prescribe, order, recommend or approve a medical service or supply does not automatically mean that We will cover that service. We will only cover benefits expressly stated as covered in this Certificate, or otherwise approved by Us.

Coverage of Service when a Network Provider's Relationship is Terminated with Cigna
If You are receiving Covered Services from a Network Provider who no longer is a Participating Provider with the Plan, We will provide payment for Covered Services under this Certificate in accordance with the "Continuity of Care" provision.

Non-Network Maternity care
Maternity care will not be covered at the Network amount if received outside the Service Area, if the delivery is normal term. However, We do cover treatment of

unexpected complications of pregnancy and care for unexpected early delivery as Emergency Services, which means that We would cover Non-Network Providers at the Network Provider rate.

Covered Service Location Cost Sharing

As indicated on Your Schedule of Benefits, certain Covered Services will subject You to a Cost Sharing obligation based on the type of facility where the Covered Service is provided. Some examples of this are dental anesthesia and Hospice services. Location Cost Sharing is in addition to any Cost Sharing obligation for the Covered Service being provided to You.

Second Opinion Coverage

We will cover a second opinion relating to a Covered Service when received from an In-Network Physician at the same cost You would pay for an initial medical opinion or consultation. In the event there is no In-Network Physician with the expertise necessary to provide a second medical opinion, then We will arrange for You to see a Physician with the necessary expertise to obtain a second opinion or consultation through our Prior Authorization process. This benefit is offered at no greater cost to You than You would pay for an initial medical opinion or consultation. If the second opinion is for a Covered Service for a specific cancer diagnosis when a Member is newly diagnosed with cancer, such coverage shall be subject to the same Deductible and Coinsurance conditions applied to other Specialist visits and all other terms and conditions applicable to other benefits, including the Prior Authorization and/or Referral authorization requirements as specified in this Certificate.

Identification of Covered Services

Subject to all terms, conditions, definitions, exclusions and limitations in this Certificate, a Member is entitled to receive the following Covered Services as set forth in this Section. All Covered Services must be Medically Necessary except for Preventive Services as set forth in the "Preventive Services" provision in this Certificate.

Preventive Care

We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Network Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (ACIP). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an

office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply.

You may contact Us at 1-855-672-2789 or visit Our website at www.hioscar.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP. You may also visit the following federal government websites for more information:

- http://www.healthcare.gov/center/regulations/prevention.html
- http://www.ahrq.gov/clinic/uspstfix.htm
- http://www.cdc.gov/vaccines/recs/acip/

Well-Baby and Well-Child Care

We Cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per Benefit Period, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit.

Immunizations and boosters as required by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age eighteen (18) and is not subject to Copayments, Deductibles or Coinsurance when provided by a Network Provider.

Adult Annual Physical Examinations

We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, cholesterol screening, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening, and diabetes screening. A complete list of the Covered preventive Services is available on Our website at www.hioscar.com, or will be mailed to You upon request.

You are eligible for a physical examination once every Benefit Period, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Network Provider.

Adult Immunizations
We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Network Provider.

Well-Woman Examinations.
We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at www.hioscar.com, or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may be less frequent than described above, and when provided by a Network Provider.

Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.
We Cover mammograms for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We Cover mammograms and BRCA counseling about genetic testing as recommended by the Member’s Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided by a Network Provider.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Copayments,

Deductibles or Coinsurance when provided by a Network Provider.

We Cover an annual chlamydia screening test for covered females age 29 and under and will include coverage for any laboratory test of the urogenital track which specifically detects for infection by one or more agents of chlamydia trachomatis and which test is approved for such purposes by the federal Food and Drug administration.

Family Planning and Reproductive Health Services.
We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the **PHARMACY BENEFITS** section of this Certificate, counseling on use of contraceptives and related topics, and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Network Provider.

We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance. We do not Cover services related to the reversal of elective sterilizations.

Bone Mineral Density Measurements or Testing
We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the **PHARMACY BENEFITS** section of this Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for Coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided

in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Network Provider.

Screening for Prostate Cancer

We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 45 and over who are asymptomatic and for men age 40 but less than 45, if the test is ordered by a physician. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

Screening for Ovarian Cancer

We Cover an annual ovarian cancer surveillance test for women age 35 and over at risk for ovarian cancer. Such tests are defined as annual screening using (a) CA-125 serum tumor marker testing; (b) transvaginal ultrasound; and (c) pelvic examination.

A woman at risk for ovarian cancer is defined as:

- Having a family history:
    - with one or more first or second-degree relatives with ovarian cancer;
    - of clusters of women relatives with breast cancer;
    - of nonpolyposis colorectal cancer; or
- Testing positive for BRCA1 or BRCA2 mutations.

Smoking Cessation

We Cover a screening for tobacco use and, for those who use tobacco products, at least two (2) cessation attempts per year, not subject to Copayments, Deductibles or Coinsurance. For this purpose, covering a cessation attempt includes coverage for:

- Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without Prior Authorization; and
- All Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a Health Care Professional without Prior Authorization.

Colorectal Cancer Screening

We cover colorectal cancer screening, examinations, and laboratory tests in accordance with the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology, for the ages, family histories, and frequencies referenced in such guidelines and recommendations; and deemed appropriate by the

attending physician after consultation with the patient.

Medically necessary preventive colonoscopies are not subject to Copayments, Deductibles or Coinsurance when provided by a Network Provider.

Emergency Ambulance Transportation

We Cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service. Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre- Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

"Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance. In the absence of negotiated rates, We will pay a Non-Network Provider the usual, customary and reasonable amount for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable.

We Cover Pre-Hospital Emergency Medical Services and emergency ambulance transportation worldwide.

Non-Emergency Ambulance Transportation

We Cover non-emergency ambulance transportation by a licensed ambulance service between Facilities when the transport is any of the following:

- From a Non-Network Hospital to a Network Hospital;

- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

Limitations/Terms of Coverage

- We do not Cover travel or transportation expenses, unless:
    - For Emergency Services
    - For non-emergent, medically necessary facility transfers,
    - For transplant services
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- Ambulance Services are subject to Medical Necessity review by Us. We retain the right to select the air ambulance provider.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
    - The point of pick-up is inaccessible by land vehicle; or
    - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

Emergency Care (including Emergency Room Services)

We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital. For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

We will Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or Stabilize Your Emergency Condition in a Hospital. We will review the emergency services claim under the prudent layperson standard. If We determine that We do not have sufficient information necessary to decide the emergency services claim, We will notify You

and the healthcare provider(s) through the Explanation of Benefits. This notice will specifically describe the required information and the prudent layperson standard. You will have 45 days from receipt of the notice within which to provide the information.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

1. Hospital Emergency Department Visits. In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department. We do not Cover follow-up care or routine care provided in a Hospital emergency department. You should contact Us to make sure You receive the appropriate follow-up care.
2. Emergency Hospital Admissions. In the event that You are admitted to the Hospital, You or someone on Your behalf must notify Us at the number on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

Payments Relating to Emergency Services Rendered.

The amount We pay a Non-Network Provider for Emergency Services will be the amount We have negotiated with the Non-Network Provider for the Emergency Service or an amount We have determined is reasonable for the Emergency Service, less any Copayment, Coinsurance or Deductible. However, the amount We determine is reasonable will not exceed the Non-Network Provider's charge and will be at least the greater of: 1) the amount We have negotiated with Network Providers for the Emergency Service (and if more than one amount is negotiated, the median of these amounts); 2) the amount for the Emergency Service calculated using the same method Plan generally uses to determine payments for Non-Network Services or 3) the amount that would be paid under Medicare for the Emergency Service.

You may be responsible for the difference between the Non-Network Provider's charge and the amount We determine is reasonable, in addition to any applicable Coinsurance, Copayment or Deductible.

Urgent Care

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. If You experience an accidental injury or a medical problem, We will determine whether Your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on Your symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If You call Your Physician prior to receiving care for an urgent medical problem and Your Physician authorizes You to go to an emergency room, Your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.

Allergy Testing
We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including injections and serums.

Chemotherapy
We Cover chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents.

Chiropractic Services
We Cover chiropractic care when performed by a Doctor of Chiropractic (chiropractor) in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Evidence of Coverage.

Cancer Clinical Trials
Benefits are available for services for routine patient care rendered as part of an approved cancer clinical trial if the services are otherwise Covered Services under this Certificate. Approved cancer clinical trials means a phase I, II, III, or IV clinical trial, conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial must meet all of the following criteria:

- The purpose of the trial is to test whether the intervention potentially improves the trial participant's health or the treatment is given with the intention of improving the trial participants health, and is not designed simply to test toxicity or disease pathophysiology;
- The trial does one of the following:

    - Tests how to administer a health care service, item, or drug for the treatment of cancer;
    - Tests responses to a health care service, item, or drug for the treatment of cancer;
    - Compares the effectiveness of health care services, items, or drugs for the treatment of cancer; or
    - Studies new uses of health care services, items, or drugs for the treatment of cancer;
- The trial is approved by one of the following:
    - The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services;
    - The FDA;
    - The United States Department of Defense; or
    - The United States Department of Veteran's Affairs.

Benefits do not, however, include the following:

- A health care service, item, or drug that is the subject of the cancer clinical trial or is provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;
- A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

Dental Services

We Cover dental services for dental work and oral surgery if they are for the initial repair of an injury to the jaw, teeth, mouth or face which are required as a result of accident only. These services must not be excessive in scope, duration, or intensity. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed as soon as reasonably possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- oral examinations.
- x-rays.
- tests and laboratory examinations.
- restorations.
- prosthetic services.
- oral surgery.
- mandibular/maxillary reconstruction.
- anesthesia.

Other

We Cover Facility charges for Outpatient services for dental expenses that are Covered Services. Benefits are payable for the removal of teeth or for other dental processes only if Your medical condition or the dental procedure requires a Hospital setting to ensure Your safety.

Pediatric

See the Pediatric Dental Care section of this Certificate for Covered pediatric services.

Anesthesia for Dental Procedures

Benefits are payable for general anesthesia/radiation therapy and associated facility charges for dental procedures rendered in a Hospital or Ambulatory Surgical Center for:

- an Member who is a child under the age of 7;
- a Member at any age who is developmentally disabled; or
- an Member whose health is compromised and general anesthesia is Medically Necessary.

Dialysis

We Cover dialysis treatments of an Acute or chronic kidney ailment, which may include the supportive use of an artificial kidney machine.

Habilitation Services

We Cover the following habilitative services, as ordered and performed by a health care practitioner, for a covered person, with a developmental defect or congenital anomaly, to learn or improve skills and functioning for daily living:

Physical therapy services;
Occupational therapy services;
Speech therapy or speech pathology services; and
Audiology services.

Habilitative services apply toward the Rehabilitative services maximum number of visits specified in the "Schedule of Benefits".

Home Health Care

We Cover benefits for covered expenses incurred by You in connection with a home health care plan. All home health care services and supplies must be provided on a part-time or intermittent basis to You in conjunction with the approved home health care plan. The "Schedule of Benefits" shows the maximum number of visits allowed by a representative of a home health care agency, if any. A visit by any representative of a home health care agency of two hours or less will be counted as one visit.
Home health care covered expenses include:

- Care provided by a nurse;
- Physical, occupational, respiratory or speech therapy, medical social work and nutrition services;
- Charges for services of a home health aide; and
- Medical appliances, equipment and laboratory services.

Home health care covered expenses do not include:

- Charges for mileage or travel time to and from the covered person's home;
- Wage or shift differentials for any representative of a home health care agency;
- Charges for supervision of home health care agencies;
- Custodial care; or
- The provision or administration of self-administered injectable drugs; unless otherwise determined by us.
- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient’s immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Infertility Treatment

We Cover diagnostic and exploratory procedures to determine infertility, including surgical procedures to correct diagnosed diseases or conditions.

Interruption of Pregnancy

We Cover therapeutic abortions. A therapeutic abortion is one performed to save the live or health of the mother or in cases of rape or incest.

Infusion Therapy

We Cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required You to be hospitalized. Drugs

or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy.

We cover home infusion therapy if You obtain preauthorization (if applicable). Benefits for home infusion therapy include a combination of nursing, DME and Drug services which are delivered and administered intravenously in the home. Home infusion therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy. Any visits for home infusion therapy count toward Your home health care visit limit.

Laboratory Procedures and Radiology Services

We Cover x-ray and laboratory procedures, testing, services and materials, including x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

Maternity and Newborn Care

We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Certificate for coverage of Inpatient maternity care.

If You are pregnant when coverage begins and are in the first trimester of the pregnancy, You must change to a Network Provider to have Covered Services paid at the Network level. If You are pregnant when coverage begins and are in Your second or third trimester of pregnancy (13 weeks or later), You may continue obstetrical care with Your Non-Network Provider through the end of the pregnancy and the immediate post-partum period. However, You must notify Us of Your intention to remain with Your Non-Network Provider.

We Cover breastfeeding support, counseling and supplies, not subject to Copayments, Deductibles or Coinsurance, including the cost of renting or the purchase of one (1) breast pump per Benefit Period.

Medical Pharmaceuticals

We cover charges made for Medical Pharmaceuticals that are administered in an Inpatient setting, Outpatient setting, Physician’s office, or in a Member's home.

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Us), 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; insulin, pre-filled insulin cartridges for the blind, pre-filled insulin pens and cartridges, oral blood sugar control agents, glucose test strips, visual reading ketone strips & urine test strips, alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes.

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.

We determine whether utilization management requirements or other coverage conditions should apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, Our evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. When considering a Medical Pharmaceutical for a coverage status, We will review clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under your plan, whether a particular prescription drug product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

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

Office Visits

We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include Home Visits.

Outpatient Hospital Services

We Cover Hospital services and supplies as described in the Inpatient Services section

of this Certificate that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

Preadmission Testing

We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

Rehabilitation Services

We Cover expenses incurred by you for the following physical rehabilitative services for a documented functional impairment, pain, or developmental defect that is ordered and performed by a health care practitioner:

- Physical therapy services;
- Occupational therapy services;
- Spinal manipulations/adjustments;
- Speech therapy or speech pathology services;
- Audiology services;
- Cognitive rehabilitation services;
- Respiratory or pulmonary therapy services; and
- Cardiac rehabilitation services.

The "Schedule of Benefits" shows the maximum number of visits for Rehabilitative Services, if any.

Surgical Services

We Cover Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services including but not limited to:

- Performance of accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;

- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Breast Surgery.
We Cover reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Other Reconstructive and Corrective Surgery.
We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct significant deformities caused by congenital or developmental abnormalities, illness, injury, or an earlier treatment in order to create a more normal appearance;
- Performed to restore symmetry after a mastectomy;
- Needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan; or
- Otherwise Medically Necessary.

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder
We Cover Benefits for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

Transplant Services and related Specialty Care

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

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

All Transplant services, other than cornea, are covered at 100% when received at Cigna LifeSOURCE Transplant Network® facilities. Cornea transplants are not included in the contracts with Cigna LifeSOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LifeSOURCE Transplant Network® facilities, are payable at the Network level. Transplant services received at any other facilities, including Non-Network Providers and Network Providers not specifically contracted with Cigna for Transplant services, are covered at the Non-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 surgery necessary for organ removal, organ transportation and the transportation (refer to Transplant Travel Services), hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Ventricular Assist Device (VAD) implantation procedures are covered at 100% when performed at a Cigna LifeSOURCE Transplant Network® facility with an approved heart transplant program. VAD implantation procedures received at participating facilities, specifically contracted with Cigna for those VAD services, other than Cigna LifeSOURCE Transplant Network® facilities are payable at the In-Network level. Transplant services received at any other facilities, including Non-Network Providers and Network Providers not specifically contracted with Cigna for VAD Services, are covered at the Non-Network level.

Advanced cellular therapy, including but not limited to, immune effector cell therapies and Chimeric Antigen Receptor Therapy (CAR-T) cellular therapy, is covered at 100% when performed at a Cigna LifeSOURCE Transplant Network® facility with an approved stem cell transplant program. Advanced cellular therapy received at participating facilities, specifically contracted with Cigna for those services, other than Cigna LifeSOURCE Transplant Network® facilities are payable at the In-Network level. Transplant services received at any other facilities, including Non-Network Providers and Network Providers not specifically contracted with Cigna for CAR-T services, are covered at the Non-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 or related specialty care are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation and lodging are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LifeSOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); and lodging while at, or traveling to and from the transplant site.

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

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

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

Autism Spectrum Disorder

Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.

We Cover the diagnosis and treatment of autism spectrum disorders for Members twenty (20) years of age or under.

Autism spectrum disorder means autism spectrum disorders as defined by the most recent edition of the diagnostic and Statistical Manual of Mental Disorders.

Diagnosis includes assessments, evaluations or tests to diagnose whether or not an individual has an autism spectrum disorder. The following are covered when Medically Necessary, and prescribed, provided, or ordered by a licensed physician or psychologist who determines the care to be evidence based in the most recent diagnostic and statistical Manual of Mental Disorders published by the American Psychiatric Association:

- Medical Care
- Habilitative or rehabilitative care;
- Pharmacy care;
- Psychiatric care;
- Psychological care;
- Therapy services provided by a licensed or certified speech therapist, speech-language pathologist, occupational therapist, physical therapist, or marriage and family therapist.
- Applied behavior analysis provided by a personal professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts.

Applied behavior analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Diabetic Equipment, Supplies and Self-Management Education
We cover diabetic equipment, supplies, and outpatient self-management training, including medical nutrition therapy, when Medically Necessary and prescribed by a health care practitioner, for the treatment of:
- Insulin-dependent diabetes;
- Insulin-using diabetes
- Gestational diabetes; or
- Non-insulin-using diabetes.

Diabetes equipment means blood glucose monitors and glucose monitors, including monitors designed to be used by legally blind or visually impaired individuals; injection aids, including those adaptable to meet the needs of the legally blind; insulin pumps and associated accessories; insulin infusion devices; and podiatric appliances and therapeutic shoes for the prevention of complications associated with diabetes; pen-like insulin injection devices; lancing devices associated with the drawing of blood samples for use with blood glucose monitors; and other medical equipment non-disposable and durable medical equipment consistent with the current standards of care of the American Diabetes Association.

Diabetes self-management training means the training provided to a covered person after the initial diagnosis of diabetes for care and management of the condition including nutritional counseling and use of diabetes equipment and supplies. It also includes training when changes are required to the self- management regime and when new techniques and treatments are developed.
Outpatient self-management training and education must be provided by a certified, registered, or licensed health care professional, which has expertise in diabetes. Covered expenses for outpatient self-management training and education will conform to current standards established by the American Diabetes Association.

Diabetes supplies. Please refer to your Pharmacy Benefits.
Durable medical equipment means equipment that meets all of the following criteria:
• It is prescribed by a health care practitioner;
• It can withstand repeated use;
• It is primarily and customarily used for a medical purpose rather than being primarily for comfort or convenience;
• It is generally not useful to you in the absence of sickness or bodily injury;
• It is appropriate for home use or use at other locations as necessary for daily living;
• It is related to and meets the basic functional needs of your physical disorder;
• It is not typically furnished by a hospital or skilled nursing facility;
• It is provided in the most cost effective manner required by your condition, including, at our discretion, rental or purchase.

Durable Medical Equipment and Braces.
We Cover expenses incurred by You for medically necessary durable medical equipment and diabetes equipment.
At Our option, covered expense includes the purchase or rental of durable medical equipment or diabetes equipment. If the cost of renting the equipment is more than you

would pay to buy it, only the cost of the purchase is considered to be a covered expense. In either case, total covered expenses for durable medical equipment or diabetes equipment shall not exceed its purchase price. In the event we determine to purchase the durable medical equipment or diabetes equipment, any amount paid as rent for such equipment will be credited toward the purchase price.

Repair and maintenance of purchased durable medical equipment and diabetes equipment is covered expense if:

- Manufacturer's warranty is expired;
- Repair or maintenance is not a result of misuse or abuse;
- Maintenance is not more frequent than every six months; and
- Repair cost is less than replacement cost.

Replacement of purchased durable medical equipment and diabetes equipment is a covered expense if:

- Manufacturer's warranty is expired;
- Replacement cost is less than repair cost; and
- Replacement is not due to lost or stolen equipment, or misuse or abuse of the equipment; or
- Replacement is required due to a change in your condition that makes the current equipment non-functional.

Gender Reassignment (Confirmation) Services

Upon Prior Authorization, We cover Medically Necessary gender dysphoria treatment.

Hospice Care Services

We will pay benefits for covered expenses incurred by you for a hospice care program. A health care practitioner must certify that the Member is terminally ill with a life expectancy of six (6) months or less. Covered Services will continue if the Member lives longer than six (6) months.

Hospice care benefits are payable as shown on the "Schedule of Benefits" for the following hospice services, subject to the individual lifetime maximum benefit and any other maximum(s):

- Room and board at a hospice, when it is for management of acute pain or for an acute phase of chronic symptom management;
- Part-time nursing care provided by or supervised by a registered nurse (R.N.) for up to eight hours in any one day;
- Counseling for the terminally ill Member and his/her immediate covered family members by a licensed Clinical social worker or Pastoral counselor.
- Medical social services provided to the terminally ill covered person or his/her immediate covered family members under the direction of a health care practitioner, including:
  Assessment of social, emotional and medical needs, and the home and family situation; and
  Identification of the community resources available;
- Psychological and dietary counseling;
- Physical therapy;

- Part-time home health aid services for up to eight hours in any one day; and
- Medical supplies, drugs, and medicines prescribed by a health care practitioner for palliative care.

Hospice care covered expenses do not include:

- A confinement not required for acute pain control or other treatment for an acute phase of chronic symptom management;
- Services by volunteers or persons who do not regularly charge for their services;
- Services by a licensed pastoral counselor to a member of his or her congregation. These are services in the course of the duties to which he or she is called as a pastor or minister; and
- Bereavement counseling services for family members not covered under this master group contract.

Medical Supplies.

Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the supplies, equipment or appliances are not received from the Pharmacy's Mail Service or from a Network Pharmacy. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Prescription Drugs and biologicals that cannot be self administered are provided in a Physician's office. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

- Allergy serum extracts
- Chem strips, Glucometer, Lancets
- Clinitest
- Needles/syringes
- Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Prosthetics.

We Cover Prosthetics that are artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

- Replace all or part of a missing body part and its adjoining tissues; or
- Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
- Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis)
- Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered Services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We cover a single purchase (including repair and/or

replacement) of hearing aids for one (1) or both ears once every three (3) years.

Bone anchored hearing aids are covered when Medically Necessary. If You meet the criteria for a bone anchored hearing aid, Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Certificate. We cover repair and/or replacement of a bone anchored hearing aid only for malfunctions.

Wellness Program.
The purpose of the wellness program is to encourage You to take a more active role in managing Your health and well-being. Throughout the course of the year, We may provide incentives in connection with the use of or participation in wellness and health promotion actions and activities, including but not limited to: a health risk assessment tool, health risk assessment visits, a designated smoking cessation program, a designated weight management program, self-management of chronic diseases, self-management of follow-up care, use of Cigna designated high-value providers, obtaining preventive care, one annual wellness exam per adult Member Plan Year through a Cigna designated Telehealth or Telemedicine Provider or through an in-home health assessment facilitated by Us, and a designated health or fitness program (such as step tracking).

Rewards for participation in the wellness program may include but are not limited to the waiver or reduction of Copayments, Coinsurance, or Deductibles; full or partial reimbursement of the cost of participating in smoking cessation or weight management programs; payment for care-adjacent services that directly address social determinants of health, such as transportation to medical visits, or food costs; and monetary rewards and financial incentives in the form of gift cards. We encourage You to use Your gift card for a product or service that promotes good health, such as healthy cookbooks, over-the-counter vitamins or exercise equipment. Based on the terms of the program being offered, You (the Subscriber), and in some cases, Your Dependent(s) 18 years of age or older can receive rewards. You are responsible for any taxes related to the redemption of rewards. For more information, visit Our website at www.hioscar.com or call Us at 1-855-672-2789. We are committed to helping you achieve your best health. If you think you might be unable to participate in this program, you might qualify for an opportunity to earn the same reward in a different way. Contact Your Customer Service team at 1-855-672-2789 and We will work with you (and, if you'd like, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. Our wellness program and any products and services available under this program are not Covered Services under the Plan.

Incentives

We may offer incentives to Members who participate in programs that help reduce Our administrative expenses; make retaining coverage more convenient; educate Members; or provide input on Us and Our products. Such programs may include paying Premiums electronically instead of receiving a paper bill; learning more about health insurance and/or specific Plan features; participating in surveys about Us and our network, products and services; discounts for paying medical bills through Our Member portal; and scheduling a provider through the Our portal. We may also offer giveaways and discounts to Members, such as discounts on select vendor partner products and services. The products and services available under this program are not Covered Services under the Plan. As such, program features are not guaranteed under the Plan and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Hospital Services.

We Cover Inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, butnot including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x- ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits apply to a continuous

Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days.

Observation Services
We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

Inpatient Medical Services
We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

Inpatient Stay for Maternity Care
We Cover Inpatient maternity care in a Hospital for the mother, and Inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal vaginal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also cover any additional days of such care that We determine are Medically Necessary. If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission, apart from the Maternity and ordinary routine nursery admission. Separate Inpatient Cost-Sharing will apply.

If the mother or newborn are discharged prior to the expiration of the applicable number of hours of Inpatient care required to be covered, follow-up care will be covered and provided within 72 hours after discharge. Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if Your attending Physician determines further Inpatient postpartum care is not necessary for You or Your newborn child, provided the following are met and the mother concurs:

- Your attending Physician believes the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
    - the antepartum, intrapartum, and postpartum course of the mother and infant;

- the gestational stage, birth weight, and clinical condition of the infant;
- the demonstrated ability of the mother to care for the infant after discharge; and
- the availability of post-discharge follow-up to verify the condition of the infant after discharge.

Covered Services include at-home post delivery care visits at Your residence by a Physician or Nurse performed no later than 72 hours following You and Your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

- parent education;
- assistance and training in breast or bottle feeding; and
- performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for You or Your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At Your discretion, this visit may occur at the Physician's office.
Physician-directed follow-up care after delivery is also covered. Services covered as follow-up care include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any Medically Necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage applies to services provided in a medical setting or through home health care visits. Home health care visit are Covered only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

Inpatient Stay for Mastectomy Care.
We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

Skilled Nursing Facility.
We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room. Custodial, convalescent or Domiciliary Care is not Covered (see the **EXCLUSIONS** section of this Certificate). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us.

Please see the Schedule of Benefits for benefit limits.

Limitations/Terms of Coverage.

- When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
- We do not Cover radio, telephone or television expenses, or beauty or barber services.
- We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care, unless Our denial is overturned by an independent reviewer.

Behavioral Health Services

Behavioral Health Services also includes coverage for Behavioral Health Conditions and Biologically Based Mental Illness services. Biologically Based Mental Illness means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

We cover intermediate levels of care, such as residential treatment, partial hospitalization and intensive outpatient services.

Please refer to the Schedule of Benefits for Cost-Sharing requirements and any Preauthorization or Referral requirements that apply to these benefits.
This Plan is compliant with the Mental Health Parity and Equity Act.

Behavioral Specialty Coaching & Support Programs

Focused on complex behavioral conditions such as autism, eating disorders, and substance use. Coaches use motivational interviewing to elicit thinking and decision making to drive positive behavior change for reasons important to the individual. Coaches can refer to appropriate medical, wellness and pharmacy programs.

Telehealth and Telemedicine

We cover Medically Necessary Covered Services offered through Telehealth or Telemedicine providers. Visits offered through Telemedicine from certain Cigna-designated Telehealth or Telemedicine Providers are covered in full. These visits can be requested through Our website, mobile application, and our customer service line. Call customer service at 1-855-672-2789 or contact them via Our website at

www.hioscar.com for additional information.

Pediatric Vision Care

We Cover emergency, preventive and routine vision care for Members through the end of the month in which the Member turns 19 years of age.

Vision Examinations

We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time in any 12-month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

Prescribed Lenses and Frames

We Cover standard prescription lenses or contact lenses one (1) time in any 12-month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also Cover standard frames adequate to hold lenses one (1) time in any 12-month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation. If You choose a non-standard frame, We will pay the amount that We would have paid for a standard frame and You will be responsible for the difference in cost between the standard frame and the non-standard frame.

Pediatric Vision Exclusions

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eye, eyes or supporting structures.
- Any services and/or materials required by an employer as a condition of employment.
- Expenses for missed appointments.
- Any charge from a providers' office to complete and submit claim forms.
- Treatment relating to or caused by disease.
- Non-prescription materials or vision devices.
- Costs associated with securing materials.

• Pre- and post-operative services.
• Orthokeratology.
• Maintenance of materials.
• Two or more pair of glasses, in lieu of bifocals or trifocals.
• Safety lenses and frames.
• Contact lenses, when benefits for frames and lenses are received.
• Oversized 61 and above lens or lenses.
• Cosmetic items.
• Refitting or change in lens design after initial fitting.
• Artistically painted lenses.
• Premium lens options;
- Blended lenses;
- Progressive multifocal lenses;
- Photochromatic lenses; tinted lenses, sunglasses, prescription and plano;
- Laminating of lens or lenses, or fashion or gradient tinting;
- Groove, drill or notch, and roll and polish; or
- Hi Index, aspheric and non-aspheric styles.

Pediatric Dental Care
For Members up to age 19, We cover medically necessary dental services including diagnostic services, preventive services, restorative services, adjunctive services, implants, and orthodontics, as determined by the standards of generally accepted dental practice. The dental benefits only apply to Members until the end of the month in which the Member turns nineteen (19) of age.

This Plan covers the Dental Services Below, when they are performed by a Network Provider (licensed dentist) and when they are necessary and customary, as determined by the standards of generally accepted dental practice. Covered Services received from a Non-Network Provider are not covered, unless otherwise described in this Certificate. If there is more than one professionally acceptable treatment for Your dental condition, the Plan will cover the least expensive treatment.

We only cover the procedures and services listed in Section, “Pediatric Dental Covered Services.” Additional requests, beyond the stated frequency limitations shall be considered when documented dental necessity is justified due to a physical limitation and/or an oral condition that prevents daily hygiene. If a Member receives a service listed in Section, Pediatric Dental Exclusions or if the Member exceeds the Benefit Limit, the Member will be financially responsible for all charges or fees associated with the service.

Pediatric Dental Covered Services.

Cigna covers five categories of pediatric dental services, Diagnostic and Preventative, Routine/Basic Services, Major Services, Medically Necessary Orthodontics and emergency treatment all subject to annual limitations. Each is subject to a different cost-share as noted in the Schedule of Benefits.

Diagnostic and Preventive	**Limitations**
Exams	One (1) per six (6) months
Bitewing x-rays	Two (2) per calendar year
Full mouth x-rays	1 every 36 mo
Cleanings	One (1) per six (6) months
Fluoride	One (1) per six (6) months
Space maintainers	As a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop, one (1) every thirty-six (36) months
Sealants	One (1) every 36 month on permanent first and second molars
Palliative	No limit

Routine/Basic Services	**Limitations**
Amalgams (resin and composites)	One (1) per surface per tooth every thirty-six (36) months
Pre-fab crowns, sedative fillings	One (1) per surface per tooth every thirty-six (36) months
Non-Surgical Periodontia (Deep cleanings, Perio maintenance, Full mouth debridement)	One (1) per site/quadrant in every thirty-six (36) month period
Simple Oral Extractions	

Major Services	**Limitations**
Inlays, Onlays, Crowns, Pin retention	One (1) per surface per tooth every forty (40) months
Endodontics	See below
Surgical Periodontics	One (1) every twenty-four (24) mo per area of the mouth
Major Oral Surgery	Subject to Prior Authorization
General Anethesia/ IV Sedation (in conjunction with oral surgery)	Subject to Prior Authorization
Removable Prosthodontia (Complete, Immediate, Removable and Partial Dentures)	One (1) every sixty (60) months
Implants (includes both primary and permanent teeth)	One (1) per tooth every sixty (60) months

Medically Necessary Ortho	Limitations
Comprehensive Orthodontic services	One (1) per lifetime

Endodontics
We Cover root canals, apexification/recalcification, apicoectomy, and hemisection, including procedures for treatment of diseased pulp chambers, pulp canals, and therapeutic pulpotomy, where Hospitalization is not required. Pulpotomy included with cost of root canal if root canal was complete within forty-five (45) days of pulpotomy.

Service	Limitation
Therapeutic pulpotomy (excluding final restoration)	One (1) per primary tooth
Pulpal debridement, partial pulpotomy and pulpal therapy	One (1) per tooth
Root canal and internal root repair	
Root canal therapy	Initial treatment is covered once (1) per tooth per lifetime Retreatment is limited to once (1) after twelve (12) months of initial treatment

Prosthodontics:
Benefits include the following:

1. Fixed bridges – Bridges made of cast, porcelain baked with metal, or plastic processed to gold are covered as follows:
    a. A fixed bridge is covered when it is necessary to replace a missing permanent anterior (front) tooth and the patient's oral health and general dental condition permits
    b. Fixed bridges are covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered an Optional Treatment
    c. Fixed bridges used to replace missing posterior teeth are considered Optional Treatment when the abutment teeth are sound and would be crowned only for the purpose of supporting a pontic
    d. Fixed bridges are considered Optional Treatment when provided in connection with a partial denture on the same arch
    e. Replacement of a fixed bridge is covered only if the existing bridge cannot be made satisfactory by repair
2. Fixed partial denture repair
3. Recementation of bridges
4. Unspecified fixed prosthodontic procedure, by report
5. Dentures (Including full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers and prosthetics.) Dentures are covered as follows:

Service	Limitation
Complete and partial dentures	One (1) per arch every five (5) Year period

Immediate dentures	One (1) per arch per patient.
Adjustments	Two (2) per arch every twelve (12) months, one (1) per arch per date of service per provider
Replacement of missing or broken teeth	four (4) per arch per provider, limited to twice (2) every twelve (12) months per provider
Repairs for resin denture base, and cast framework limited	Two (2) per arch per provider every twelve (12) months, limited to one (1) per arch per date of service per provider
Repair or replace broken clasp	Three (3) per arch per provider every twelve (12) months, limited to one (1) per arch per date of service per provider
Replace broken teeth	Four (4) per arch per provider every twelve (12) months, limited to one (1) per arch per date of service per provider
Add tooth	Three (3) per arch per date of service per provider, one (1) per tooth
Add clasp to existing partial denture	Three (3) per date of service per provider, twice (2) per arch per provider every twelve (12) months
Complete or Partial denture Relines	One (1) every twelve (12) months, covered six (6) months after initial placement of appliance if extractions were required, twelve (12) months after initial placement of appliance if extractions were not required
Tissue conditioning	Two (2) per arch every thirty-six (36) months
Complete overdenture	One (1) per arch every five (5) Year period

Pediatric Medically Necessary Ortho Coverage
The determination of Medical Necessity will be made by the Provider in accordance with guidelines established by the Plan. When there is a conflict of opinion on whether or not a service or procedure is Medically Necessary between the Provider and the Plan, the opinion of the Plan will be final.

Orthodontia procedures will only be approved for:

- Dentofacial abnormalities that severely compromise the Member's physical health; or
- A serious handicapping malocclusion.
    - Presence of a serious handicapping malocclusion is determined by the magnitude of the following variables:
        - Degree of malalignment;
        - Missing teeth;
        - Angle classification;
        - Overjet and overbite;
        - Open bite and crossbite.

Orthodontic needs must meet medically necessary requirements as determined by a

verified score of 26 or higher (or other qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.

If for any reason orthodontic services are terminated or coverage under the Plan is terminated before completion of the approved orthodontic treatment, the responsibility of the Plan will cease with payment through the month of termination.

Pediatric Emergency Dental
We Cover emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization.

Pediatric Dental Exclusions

1. Any procedures not covered under this Plan.
2. Provided to Members by a Non-Network Provider except when immediate dental treatment is required as a result of a Dental Emergency occurring more than 50 miles from the Member's home.
3. Dental procedures or services performed solely for Cosmetic purposes or that is not Dentally Necessary and/or medically necessary.
4. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving You or Your Dependent's dental health, as determined by Us based on generally accepted dental standards of care.
5. For elective procedures, including prophylactic extraction of third molars.
6. Replacement of Dentures, Crowns, appliances or Bridgework that have been lost, stolen or damaged.
7. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a Pediatric Dental Covered Service. Any services related to pathology laboratory fees.
8. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
9. Treatment required due to an accident from an external force or are intentionally self-inflicted, unless otherwise listed as Pediatric Dental Covered Service.
10. Services that restore tooth structure due to attrition, erosion or abrasion are not covered.
11. The following are not included as Orthodontic benefits:
    a. Repair or replacement of lost or broken appliances;
    b. Retreatment of Orthodontic cases;
    c. Treatment involving: Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia; Hormonal imbalances or other factors affecting growth or developmental abnormalities, unless specifically covered as medically necessary orthodontia;
    d. Treatment related to temporomandibular joint disorders, unless specifically covered as medically necessary orthodontia;
    e. Composite or ceramic brackets, lingual adaptation of Orthodontic bands

and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances. Invisalign services are excluded.

12. Broken appointments.
13. For Prescription or nonprescription drugs, home care items, vitamins or dietary supplements.

Please submit appeals regarding Your dental coverage for Members under nineteen (19) years of age to the following address:

Cigna Health and Life Insurance Company
c/o Liberty Dental Plan
PO BOX 26110
Santa Ana, CA 92799

PHARMACY BENEFITS

Formulary Drugs

We maintain a list of medications, typically a portion of those approved by FDA, that We will cover. This list, referred to as the Formulary, is reviewed and updated by Us on a regular cycle. Our Pharmaceutical and Therapeutics Committee oversees the review process to ensure clinical, quality and cost considerations are appropriately considered. Our Formulary includes medications in almost all classes of medications, but does not necessarily include all forms of a given Prescription Drug (e.g. oral tablets, liquids, topical etc.).

We update the Formulary on an ongoing basis, but when modifying always ensure it is effective uniformly among all individuals in a given plan type. When changes are made, We will notify both you and the Insurance Commissioner in accordance with federal and state specific law.

The coverage status of a medication may change periodically for various reasons. For example, a medication may be removed from the market, a new medication in the same therapeutic class may become available, or other market events may occur. Market events that may affect the coverage status of a medication include, but are not limited to, an increase in the acquisition cost of a medication. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that medication, to obtain the medication from a certain Pharmacy (ies) for coverage, or try another covered medication. Please visit our website at www.hioscar.com or call Us at 1-855-672-2789 for the most up-to-date tier coverage status, utilization management, or other coverage limitations for a Prescription Drug Product.

To receive coverage for a Formulary medication, you must have a health care provider prescribe you the medication and the medication must be determined by Us to be Medically Necessary, (see Section: How do you get it).

To request coverage for a medication not listed on the Formulary, you or your health care provider can submit a request (see 'What if I disagree') section. If You have a question

regarding whether a Drug is on the Formulary, please visit Our website at www.hioscar.com or call Us at 1-855-672-2789.

Diabetes Supplies for Treatment of Diabetes
Your Plan covers Medically Necessary diabetic supplies, but as with all covered medications, you are responsible for cost-sharing amount as applicable.
Common supplies your plan covers include (but are not limited to):

- Test strips specified for use with a corresponding blood glucose monitor
- Lancets and lancet devices
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
- Insulin and insulin analog preparations
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin syringes
- Biohazard disposable containers
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- Glucagon emergency kits.

Vaccinations and Administration
Your Plan covers Medically Necessary vaccinations. Vaccinations can be administered by any health care provider, including in most states, pharmacists.

However, not all pharmacists provide vaccinations, so we encourage you to contact them in advance. All vaccinations, when administered per ACIP (Advisory Committee on Immunization Practices) guidelines, will not be subject to copayments, coinsurances, or deductible.

Medical Foods
Your Plan covers Medical Foods and any Medically Necessary services associated administration. Coverage may be subject to utilization review, including periodic review, of the continued Medical Necessity of the product. Medical foods includes but is not limited therapeutic food, formulas, amino acid-based elemental formula, or low-protein modified food products that are indicated for the therapeutic treatment of inborn errors of metabolism or genetic conditions and are administered under the direction of a physician.

Drugs Used in Treatment of Cancer
Your Plan covers Medically Necessary medications for the treatment of cancer. We require the drug to either be approved by the FDA or to have been studied in scientific literature as safe and effective for your specific type of cancer such as the National Comprehensive Cancer Network Guidelines or other Nationally recognized clinical guidelines. If You have a question regarding whether a Drug is covered call Us at 1-855-672-2789.

We cover medications used for treating cancer-related pain even if the dosage administered exceeds the standard FDA approved amount, if deemed Medically Necessary by your Healthcare Provider.

Orally Administered Anticancer Medication

Your Plan covers Medically Necessary orally administered anticancer medication. This Coverage will be equal to or better than intravenously administered or injected cancer medications that are covered under the medical benefit portion of Your Plan.

Prescription Inhalants

Your plan covers prescription inhalants required to enable persons to breathe when suffering from asthma or other life-threatening bronchial ailments. Additional inhalers must be allowed if prescribed or ordered by the treating physician regardless of any restriction on the number of days before inhaler refills may be obtained otherwise.

Injectable Drugs

Your Plan covers Medically Necessary injectable drugs. Injectable drugs are pharmaceuticals administered by needle or syringe via the skin (typically intravenously or intramuscularly). As part of this benefit, the necessary disposable needles or syringes are also covered.

Physician Administered Medications - Preferred Drug List

Your Plan covers Medically Necessary medications supplied and administered directly by a physician. These medications are commonly referred to as 'Physician Administered Medications' and are applied towards the medical benefit portion of your Plan.

We designate a subset of these Physician Administered Medications as preferred medications. The designation is developed using guidelines from the American Medical Association, Academy of Managed Care Pharmacies, and other clinical organizations, describing clinical outcomes, efficacy, and side-effects. The list of preferred medications is available on www.hioscar.com/forms and is periodically reviewed, and updated by Us as the status of existing medications changes and new drugs enter the market.

Medications designated as preferred by Us may still require prior authorization.

Growth Hormone

Growth Hormone Treatment is excluded except for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during Dialysis, or for Patients with AIDS wasting syndrome. Conditions of growth hormone deficiency are defined as two abnormally low growth hormone stimulation tests of less than 10 ng/ml, one abnormally low growth hormone dependent peptide, and physiological manifestations of growth hormone deficiency in addition to low growth velocity and > 2.5 standard deviations below average height.

Continuation of growth hormone therapy will not be covered except for Conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment. Treatment is considered responsive in children less than 21 years of age, when the growth hormone dependent peptide (IGF-1) is in the normal range for age and Tanner development stage; the growth velocity is at least 2 cm per year, and studies demonstrate open epiphyses.

Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.

Smoking Cessation
Your Plan covers medically necessary pharmaceuticals to aid Smoking Cessation, in accordance with "A" or "B" recommendations of the U.S. Preventive Services Task Force not subject to Copayments, Deductibles or Coinsurance. This includes nicotine replacement therapy such as nicotine patches, gum, and lozenges.

We also cover screenings, intervention, and behavioral services for Smoking Cessation, as in accordance with "A" and "B" recommendations of the U.S. Preventive Task Force not subject to Copayments, Deductibles or Coinsurance. You may also call the National Quitline at 1-800-QUIT-NOW at any time to assist with Smoking Cessation Attempts.

Cost Sharing
The cost-sharing amount for your medications is determined by the Formulary tier of the drug being dispensed. Please see your Schedule of Benefits for more details about your plan's specific cost-sharing amounts.

In the event the negotiated amount for your medication is less than your applicable cost-sharing amount, you will pay only the negotiated amount.

Day Supply and Early Refills
Covered Drugs are provided up to the maximum day supply limit as indicated on Your Schedule of Benefits and/or Formulary. We have the right to determine the day supply and refill thresholds.
Payment for medications covered under this Plan may be denied if they are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing the stated maximum day supply limitation.

This Plan allows members to receive an early refill of certain medications in anticipation of extended travel - also known as a vacation override. A vacation override may not exceed members' eligibility expiration with Us.
Your Plan does not cover the replacement of drugs or supplies that have been lost, stolen, or destroyed.

Quantity and Time Limits
Some medications have limits, placed by Us, on the quantity that your pharmacist can

supply to you at a given time. These limits are based on clinical data from the FDA and from nationally recognized clinical guidelines. The limits apply regardless of the quantity prescribed by your Healthcare Provider.

If you or your Health Care Provider believes you require a higher quantity of medication than the limit, your Health Care Provider can submit a request to Us for an exception. One of Our clinicians will review the request based on the submitted information. Any drugs dispensed by your pharmacist in a manner intended to change or circumvent the maximum limits set by Us will be denied.

Brand Name vs Generic Drug Pricing Difference
If you or your healthcare provider request a pharmacy to fill the branded version of a medication when a generic version is available, you will pay a higher cost-sharing amount. The higher cost-sharing amount will be the applicable cost-sharing of the branded medication plus the difference in the allowed amount between the branded and generic versions.

Drug Coupons, Rebates or Other Drug Discounts
Drug Manufacturers may offer coupons, rebates or other drug discounts to Members, which may impact the benefits provided under this Plan. The total benefits payable will not exceed the balance of the Allowed Amount remaining after all drug coupons, rebates, or other drug discounts have been applied. The Member agrees to reimburse Us any excess amounts for benefits that We have paid You and for which You are not eligible due to the application of drug coupons, rebates or other drug discounts.

Some specialty medications may qualify for third party Copayment assistance programs which could lower Your out of pocket costs for those products, subject to Our prior approval. For any such specialty medication where third party Copayment assistance is used, You shall not receive credit toward their Maximum Out-of-Pocket or Deductible for any Copayment or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Medication Synchronization Plan
If you are filling more than one prescribed medication on an ongoing basis, you have the option to coordinate the refilling of your medications to a single retail pharmacy visit.

To use this program, notify your retail pharmacist at your next visit that We support this program and you'd like to coordinate your refills. Your retail pharmacist may refer to this option as a 'medication synchronization program'. The retail pharmacist will immediately submit the necessary 'early refill' requests to Us and if approved, your retail pharmacist will then fill your prescribed medications.

We will prorate on a per day basis, any Cost-Sharing amounts for a quantity that is less than a 30 days' supply when dispensed as part of a Medication Synchronization

Selecting a Participating Pharmacy
As a Member, you have two methods to fill a prescription: (1) Visiting your local Retail Pharmacy, (2) Using a Mail-Order Pharmacy (see section on Mail-Order).

If using a Retail Pharmacy, first check on our website (www.hioscar.com) or contact Member Services at 1-855-672-2789 to confirm the pharmacy is in the Cigna Network, as some large chains and smaller independents are excluded depending on your plan type. Additionally, certain drugs are not available at standard retail pharmacies (see section: Specialty Pharmacy).

At the pharmacy you will be required to present your Insurance Card and your prescription (if not already sent electronically by your Healthcare provider). The pharmacy may also require additional information to fill your prescription and process the claim. At the time of pickup, you will be required to pay any cost-sharing amounts (deductibles, coinsurance, or copayments) and pricing differences (if applicable).

Mail Order Program
Mail Order Pharmacies are an alternative way you can get your medications. Certain eligible covered drugs, such as maintenance medications can be delivered to your home. Not all Medications listed on our formulary can be filled at Mail Order. You can find more information and our Drug Formulary by going to www.hioscar.com or if You have any questions or need assistance in determining the amount of Your payment, or need to obtain the mail-order prescription form, You may contact Member Services at 1-855-672-2789.

If your Retail Pharmacy offers you a delivery option, this is not the same as our Mail Order Program. We will not prohibit your Pharmacy from offering this as an extra service. Your pharmacy will let You know of any fees associated with the delivery, including any fees not reimbursable by Us.

Benefits for Specialty Drugs
Drugs that require specialized patient education prior to use and ongoing patient assistance while under treatment are called 'Specialty Drugs'.

These 'Specialty Drugs' must be dispensed through a Cigna contracted Specialty Pharmacy. Please visit our website at www.hioscar.com or call Member Services at 1-855-672-2789 to find out if your medication is considered a Specialty Drug and/or identify the best Specialty Pharmacy option for you.

Selecting a non-Participating Pharmacy

If you choose to visit a Non-Network pharmacy and the pharmacy is willing to accept reimbursement at the same rates as a participating pharmacy, they can submit a request for reimbursement to Us. Contact us at 1-855-672-2789 if you and your pharmacy wish to pursue this option.

Prior Authorization
Some medications, despite being prescribed by your Healthcare Provider, require an additional review by a Clinician before you can fill the prescription. This process is called Prior Authorization. A Clinician performs a Prior Authorization review to ensure the prescribed drug is safe, effective, and appropriate for your specific treatment plan. A list

of the medications which require a Prior Authorization and the required forms are available on our website at www.hioscar.com or by contacting member services at 1-855-672-2789.

We will review all Prior Authorization requests and make a decision to approve or deny coverage for the requested medication based on established clinical criteria. A decision will be made within the time limits specified by State or NCQA Regulations. If you or Your Health Care Provider do not agree with the decision made by Us, you have the ability to contest the decision (see ""When you disagree').

If your health care provider does not obtain a Prior Authorization, the pharmacy will be alerted when they are attempting to submit a claim to Us and you will not be able to receive your medication.

Step Therapy

Certain medications are subject to step therapy requirements. This means that in order to receive benefits for such medications you are required to try a different medication first unless you satisfy the plan's exception criteria. You may identify whether a particular medication is subject to step therapy requirements at www.hioscar.com or by contacting member services at 1-855-672-2789.

A step therapy exception will be granted if Your prescribing Provider submits justification and supporting clinical documentation, if needed, is completed and determined to support such provider's statement that:

- The required prescription drug is contraindicated or will cause an adverse reaction or physical or mental harm to the patient;
- The required prescription drug is expected to be ineffective based on Your known clinical condition and the known characteristics of the prescription drug regimen;
- You have tried the required prescription drug or another prescription drug in the same pharmacological class or with the same mechanism of action as the required drug while on this Plan or a plan immediately preceding this Plan and such drug was discontinued due to lack of efficacy, diminished effect, or an adverse event; or
- You are currently receiving a positive therapeutic outcome on a prescription drug for the medical condition under consideration if, while on their current or immediately preceding health plan, You received coverage for the prescription drug and your Provider gives documentation that the change in prescription drug required by the step therapy protocol is expected to be ineffective or cause harm to You based on Your known characteristics and the known characteristics of the required prescription drug.

Drug samples shall not be considered trial and failure of a preferred prescription drug in lieu of trying the step therapy required prescription drug.

<u>Timeframes:</u>

We will grant or deny a step therapy exception or appeal of a step therapy exception within:

(1) Twenty-four hours in an urgent health care situation; and

(2) Two business days from the date such request or appeal is submitted in a nonurgent health care situation.

If we fail to respond in accordance with the established time frame, such step therapy exception or an appeal shall be deemed approved.

Upon the granting of a step therapy exception, we will immediately authorize coverage for the prescription drug prescribed by Your provider, provided that the drug is covered under the Plan. Any step therapy exception denial shall be eligible for Your or Your Provider's appeal in accordance with the Plan's existing appeal procedures.

Exceptions:
The above does not prevent:

- Us from requiring You to try an AB-rated generic equivalent prior to providing coverage for the equivalent-branded prescription drug;
- Us from requiring You to try an interchangeable biological product prior to providing coverage for the biological product; or
- Us from prescribing a prescription drug that is determined by such practitioner to be Medically Necessary.

This requirement will not be construed to impact Our ability to substitute a generic drug for a brand name drug.

Definitions:
'Step therapy exception' means that a step therapy protocol should be overridden in favor of immediate coverage of the Provider's selected prescription drug, provided that the drug is covered under the Plan.

'Step therapy protocol' means an evidence based and updated protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are deemed medically appropriate for a particular patient, including self-administered and physician-administered drugs, and are covered by Us.

Right of Appeal

Certain medications have requirements or restrictions placed by Us. In the event your Health Care Provider requests us to review these requirements or restrictions placed on Your Medication and the request is denied by Us, you have the right to appeal the decision.

The GRIEVANCES AND APPEALS section of this plan outlines this in more detail.

Prescription Drug Formulary Exception Request

If you or your health care provider believe your treatment needs require a medication not on the Formulary, your health care provider can submit an exception request.

The necessary form can be found on our website at www.hioscar.com. Once submitted, the exception request will be reviewed by a Clinician in accordance with state specific timeframes.

External Exception Request for Denial of Standard or Expedited Formulary Exception Request

If We deny the Formulary exception, reviewed in either a Standard or Expedited manner, a request for a review by the Independent Review Organization can be initiated by You, Your designee, or Your Healthcare Provider. These requests, also called an external exception, will be reviewed in the timeframes set forth by the Independent Review Organization and State regulations.

A Request for external exception review does not eliminate Your right to request an Appeal through Our Member Appeal procedures.

If the review is approved by the Independent Review Organization, We will cover the medication for the duration determined by the Independent Review Organization. Any drug covered through the exception process will count towards Your satisfaction of the annual limitation on Cost Sharing, also known as Your Maximum Out Of Pocket amount.

Limitations and Exclusions

1. Your Plan does not cover vitamins or dietary supplements for which there is a clinically equivalent non-prescription over-the-counter alternative. This does not apply to USPSTF endorsed preventive treatments such as prenatal vitamins and fluoride preparations.
2. Your Plan does not cover prescription drugs prescribed for the treatment of obesity or for use in any weight reduction, weight loss, or dietary control. Non-pharmacological healthy diet counseling and obesity screening, as endorsed by the USPSTF remain covered.
3. Your Plan does not cover prescription drugs used to enhance cosmetic appearance or performance. This includes, but is not limited to anti-aging, athletic performance (anabolic steroids, androgens or related), hair loss (rogaine, minoxidil or related), sweating (botox or related) and treatments for scarring.
4. Your Plan does not cover prescription drugs used to treat sexual dysfunction, including, but not limited to: sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form. These drugs are covered if prescribed to treat a Medically Necessary indication other than sexual dysfunction.
5. Your Plan does not cover prescription drugs prescribed or administered by a Dentist or Dental Specialist used to support the non-medical, dental procedures such as extractions, root canals, or periodontal treatments. This includes locally applied dental antibiotics such as Arestin+ or similar.
6. Your Plan does not cover growth hormone therapy used to treat familial short stature. This exclusion does not apply to growth hormone therapy when determined Medically Necessary to treat a medical condition other than familial short stature.
7. Your Plan does not cover oral and injectable infertility/fertility medications.
8. Your Plan does not cover vaccinations necessary solely for the purpose of travel to

a region outside of the United States.

9. Your Plan does not cover prescription drugs, devices or supplies available in an over-the-counter form or comprised of components that are available in a clinically equivalent over-the-counter form. This does not apply to over-the-counter products that We are required to cover under federal or state laws or as a USPSTF endorsed preventive service.
10. Your Plan does not cover drugs, vaccines, and supplements which are not approved by the FDA or are labeled as ""Investigational / Experimental"" use only.
11. Your Plan does not cover drugs obtained in an unauthorized manner (e.g. fraudulent identification) or drugs for which the intended use would be illegal, unethical, or otherwise improper. This includes drugs that have been repackaged by anyone other than the original manufacturer.
12. Your Plan does not cover the replacement of drugs or supplies that have been lost, stolen, or destroyed.
13. Your Plan does not cover prescriptions written as a result of 'self-prescribing' or prescriptions filled at a pharmacy owned by you or an immediate family member.
14. Your Plan does not cover compounded drugs unless it contains at least one ingredient that has been approved by the United States Food and Drug Administration (FDA). We will also not cover compounded drugs that are available as a similar commercially available Prescription Drug. All compounds are subject to a Medical Necessity review.
15. Your Plan does not cover drugs dispensed in a Medical Office, Hospital, Acute Care, or Long Term Facility for which the Office or Facility is also seeking reimbursement from Your Medical Benefit or for which they receive a Standard Daily Rate for inclusive services.
16. Your Plan does not cover prescription drugs, supplies or devices provided in connection with an occupational sickness or an injury sustained in the scope of employment.

EXCLUSIONS

This section explains what We do not cover. If You receive a service shown below, You will be responsible for paying all charges and fees associated with it.

General Exclusions

The following services are not covered under the Plan:

1. Which We determine are not Medically Necessary.
2. Received from an individual or entity that is not a Provider, as defined herein, or recognized by Us.
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.
4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.
5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
6. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
7. For a condition resulting from direct participation in a riot, civil disobedience, rebellion, insurrection, nuclear explosion, or nuclear accident.
8. For court ordered testing or care unless Medically Necessary.
9. For which You would not be legally required to pay for in the absence of insurance.
10. For the following:
    a. Surcharges for furnishing and/or receiving medical records and reports.
    b. Charges for doing research with Providers not directly responsible for Your care.
    c. Charges that are not documented in Provider records.
    d. Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
    e. For membership, administrative, or access fees charged by Physicians or other

Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

11. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
12. Prescribed, ordered or referred by or received from a member of Your immediate family, including Your spouse, child, brother, sister, parent, in-law, or self.
13. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
14. For missed or canceled appointments.
15. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or:
    a. For Emergency Services
    b. For non-emergent, medically necessary facility transfers,
    c. For transplant services
16. For which benefits are payable under Medicare Parts B, and/or D when Medicare is primary. If Medicare is not primary, this exclusion does not apply if a person is or could have been covered under another plan, except with respect to Part B of Medicare.
17. Charges in excess of Our Maximum Allowable Amounts for kidney dialysis when traveling.
18. Incurred prior to Your Effective Date.
19. Incurred after the termination date of this coverage except as specified elsewhere.
20. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Complications directly related to cosmetic services treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Certificate. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co- morbid conditions.
21. For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
22. For the following:
    a. Custodial Care, convalescent care or rest cures.
    b. resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
    c. Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, halfway house, or outward bound programs, even if

psychotherapy is included.
    d. Wilderness camps.
23. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
    a. cleaning and soaking the feet.
    b. applying skin creams in order to maintain skin tone.
    c. other services that are performed when there is not a localized illness, injury or symptom involving the foot.
24. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
25. For dental treatment, regardless of origin or cause, except as specified elsewhere in this Certificate. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:
    a. extraction, restoration and replacement of teeth.
    b. medical or surgical treatments of dental conditions.
    c. services to improve dental clinical outcomes.
26. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
27. For Dental implants.
28. For Dental braces.
29. For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, unless required by law and except as specified elsewhere in this Certificate. The only exceptions to this are for any of the following:
    a. transplant preparation.
    b. initiation of immunosuppresives.
    c. direct treatment of acute traumatic injury, cancer or cleft palate.
30. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
31. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
32. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This

exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self funded plan prior to coverage under this Certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post operative time frame.

33. For marital counseling.
34. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.
35. For vision orthoptic training.
36. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
37. For personal hygiene, environmental control, or convenience items including but not limited to:
    a. Air conditioners, humidifiers, air purifiers;
    b. Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    c. Charges for non-medical self-care except as otherwise stated;
    d. Purchase or rental of supplies for common household use, such as water purifiers;
    e. Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    f. Infant helmets to treat positional plagiocephaly;
    g. Safety helmets for Members with neuromuscular diseases; or
    h. Sports helmets.
38. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
39. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by Us, or as otherwise described in this Certificate.
40. For care received in an emergency room which is not Emergency Care, except as specified in this Certificate. This includes, but is not limited to suture removal in an emergency room.
41. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
42. For self-help training and other forms of non-medical self care, except as otherwise provided in this Certificate.

43. For examinations relating to research screenings.
44. For stand-by charges of a Physician.
45. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
46. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in this Certificate.
47. For Manipulation Therapy services rendered in the home as part of Home Care Services.
48. Services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion also includes all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
49. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
50. For any services or supplies provided to a person not covered under the Certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
51. For surgical treatment of gynecomastia.
52. For treatment of hyperhidrosis (excessive sweating).
53. If a provider waives an amount and We find that they have, We can reduce the benefit paid to adjust for these items
54. Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by Us through Prior Authorization.
55. Complications directly related to a service or treatment that is a non Covered Service under this Certificate because it was determined by Us to be Experimental/Investigational or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non Medically Necessary service.
56. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This Exclusion does not apply to over-the-counter products that We must cover under federal law with a Prescription.
57. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential

ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

58. Treatment of telangiectatic dermal veins (spider veins) by any method.
59. Reconstructive services except as specifically stated herein, or as required by law.
60. Nutritional and/or dietary supplements, except as provided in this Certificate or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
61. For room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission for Your condition.
62. For health care services provided or charges billed as a result of injuries, conditions, or disabilities suffered while or as a result of committing or attempting to commit a criminal act, unless the result of a mental health or substance use disorder condition.
63. For health care services provided or charges billed as a result of injuries, conditions, or disabilities suffered while or as a result of engaging in an illegal occupation.
64. Charges for medical evacuation and repatriation to the United States are not covered.
65. Expenses and charges for non-therapeutic abortions.
66. In vitro fertilization.
67. Vocational rehabilitation.
68. For home delivery of childbirth.
69. Coma stimulation.
70. Federal, state or local taxes due on benefits, goods or services and shipping and handling charges, except as otherwise covered in this Certificate.
71. Services provided while You are incarcerated.
72. Services, care or treatment for medical complications resulting from or associated with non-covered services.
73. Charges in excess of the Allowed Amount.

Experimental/investigative services exclusion

- Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine in Our sole discretion to be Experimental/Investigative is not covered under the Plan.
- We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:
    - cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
    - has been determined by the FDA to be contraindicated for the specific use; or
    - is provided as part of a clinical research protocol or clinical trial or is

provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

- Any service not deemed Experimental/Investigative based on the Criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:
  - the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
  - the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives;
  - the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
  - the scientific evidence is conclusory concerning the effect of the service on health outcomes.

The information considered or evaluated by Us to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or

local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

The plan will not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for:

- the treatment of a life-threatening condition or chronic/debilitating disease or condition if:
  - one of the following criteria are met:
    - coverage may be subject to the prior authorization process or other restrictions;
    - the drug is prescribed by a Physician for the treatment of a life-threatening disease or condition; or
    - the drug is prescribed by a Physician for the treatment of a chronic and seriously debilitating disease or condition, the drug is Medically Necessary to treat that disease or condition, and the drug is on the Prescription Drug List; or
    - the drug is prescribed by a Physician to treat a disease or condition in a child where the drug has been approved by the federal Food and Drug Administration for similar conditions or diseases in adults and the drug is Medically Necessary to treat that disease or condition; and
  - the drug has been recognized for treatment of that disease or condition or pediatric application by one of the following:
    - The American Medical Association Drug Evaluations;
    - The American Hospital Formulary Service Drug Information;
    - The United States Pharmacopoeia Dispensing Information, Volume I, "Drug Information for the Health Care Professional"; or
    - Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use(s) as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.
    - the treatment of cancer in the U.S. Pharmacopeia Drug Info., The American Medical Assoc. Drug Evaluations, the American Hospital Formulary Service Drug Info., or in formal clinical studies, with published results in a United States or Great Britain medical journal.

We have the authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

COMPLAINTS & GRIEVANCES

Our Complaint & Grievance procedure is intended to provide a fair, quick and inexpensive method of resolving any and all Complaints and Grievances with Us. The Complaints and Grievances procedure can be used to resolve any matters that cause You to be dissatisfied with any aspect of Your relationship with Us; any Adverse Determination concerning a claim; Rescission of Coverage; or any other claim, controversy, or potential cause of action You may have against Us.

The ComplaintProcedure
If You have a complaint, problem, or claim concerning benefits or services, please contact Us. Please refer to Your ID Card for Our telephone number. Making a verbal complaint inquiry does not stop the time period for filing a claim or beginning a Grievance. You do not have to make a verbal complaint before filing a Grievance.

The Grievance Procedure
You must submit a written request asking Us to reconsider an Adverse Determination, or to formally initiate another type of Grievance in a form required by Us. This is the first level Grievance procedure and is mandatory. Contact Us at the number on the back of Your Member ID card for assistance in preparing and submitting Your Grievance. We can provide You with the required form to use in submitting a Grievance.

You must begin the Grievance process within one-hundred and eighty (180) days from the date We issue notice of an Adverse Determination or from the date of the event that is otherwise causing You to be dissatisfied with Us. The Grievance process that was in effect on the date(s) of service for which You received an Adverse Determination will apply. If You do not initiate a Grievance within one-hundred and eighty (180) days of when We issue an Adverse Determination, You may give up the right to take any action related to that Grievance.

You will be notified of the resolution of Your Grievance relating to an Adverse Determination. We will explain why benefits were denied and describe Your rights to appeal.

The Grievance Review Procedures
After We have received and reviewed Your Grievance, we will consider Your Grievance using any additional information that You or others submit concerning that Grievance. Grievance reviewers have full authority to make determinations pursuant to this

Certificate.

Appeals
Grievances concerning Adverse Determinations, including urgent care or pre-service claims, are called Appeals. We will appoint one or more qualified reviewer(s) to consider Appeals. Individuals involved in making prior determinations concerning Your Appeal are not eligible to review your Appeal.

The reviewer will consider the information presented, and You will receive a written decision concerning Your Appeal as follows:

- For a pre-service claim, within thirty (30) days of receipt of Your request for review;
- For a post-service claim, within sixty (60) days of receipt of Your request for review; and
- For a pre-service, urgent care claim, within seventy-two (72) hours of receipt of Your request for review.

The Appeal decision will be sent to You in writing and will contain:

- A statement of the reviewer's understanding of Your Appeal;
- The basis of the decision; and
- Reference to the documentation or information upon which the reviewer based its decision. We will send You a copy of such documentation or information, without charge, upon written request.

Second Level Appeal Procedure
You may – but are not required to - file a written request for reconsideration within ninety (90) days after We issue a first level Appeal decision. This is called a second level Appeal. This step is a voluntary step in the Appeal procedure. Information on how to submit a second level Appeal will be provided to You in the decision letter following the first level Appeal review.

Any person involved in making a decision concerning Your Appeal (e.g. first level Appeal reviewers) will not make a determination concerning Your second level Appeal. Your decision concerning whether to file a second level Appeal has no effect on Your rights to any other benefits under this Certificate.

Second Level Appeal Hearing
You may request an in-person or telephonic hearing before the second level Appeal panel of reviewers. An in-person hearing must be requested within ten (10) business days after You receive notice of your first level Appeal decision. You may also request that the second level Appeal panel reconsider the decision of the first level Appeal,

even if You do not want to participate in a hearing concerning Your Appeal. If You wish to participate, Our representatives will contact You to explain the hearing process and schedule the time, date and place for that hearing.

In either case, the second level Appeal panel will meet and consider all relevant information presented about Your Appeal, including:

- Any new, relevant information that You submit for consideration; and
- Information presented during the hearing. Second level Appeal panel may ask You questions during the hearing. You may make a closing statement to the panel at the end of the hearing.
- If You wish to bring a personal representative with You to the hearing, You must notify Us at least five (5) days in advance and provide the name, address and telephone number of Your personal representative.

Written Decision

After the hearing, the second level Appeal panel will meet in closed session to make a decision concerning Your Appeal. That decision will be sent to You in writing. The written decision will contain:

- A statement of the second level Appeal panel's understanding of Your Appeal;
- The basis of the panel's decision; and
- Reference to the documentation or information upon which the second level reviewers' based their decision. Upon written request, We will send You a copy of any such documentation or information, without charge.

Independent Review of Medical Necessity Determinations or Coverage Rescission Appeals

If Your Appeal involves a Medical Necessity, Investigational, Experimental or coverage rescission determination, then either (1) after completion of the mandatory first level Appeal; or

(2) after completion of the mandatory first level Appeal immediately followed by completion of the voluntary second level Appeal, You may request that the Appeal be submitted to a neutral third party, selected by Us, to independently review and resolve such Appeal. If You request an independent review following the mandatory first level Appeal, You waive Your right to a second level Appeal and Your right to present testimony during the Appeal procedure. Your request for independent review must be submitted in writing, using the form prescribed by Us, within one-hundred and eighty (180) Days after the date You receive notice of the first or second level Appeal decision, whichever is later. Receipt shall be deemed to have occurred no more than two (2) days after the date of issuance of the Appeal decision. Any person involved in making a decision concerning Your Appeal will not be a voting member of the independent review panel or committee. Your decision concerning whether to request

independent review has no effect on Your rights to any other benefits under this Certificate.

You may request an expedited independent review when a standard independent review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if your Adverse Determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility.

Within ten (10) business days following the date We receive the copy of the standard independent review request, or immediately for expedited independent review requests, We will conduct and complete a preliminary review of the request to determine whether your request is eligible for review. Within three (3) business days after completion of the above review, or immediately If your Appeal is eligible for expedited review, We will notify you in writing whether (1) the request is complete; (2) the request is eligible for independent review; and (3) We have accepted the request for independent review.

We will pay the fee charged by the independent review organization and its reviewers if You request that We submit an Appeal to independent review. You will be responsible for any other costs that You incur to participate in the independent review process, including attorneys' fees.

We will provide copies of Your file, excluding any proprietary information, to You upon written request. The reviewer may also request additional medical information from You. You must submit any requested information, or explain why that information is not being submitted, within five (5) business days after receiving that request from the reviewer.

The reviewer must make a decision within forty (40) calendar days after receipt of the independent review request and must then notify Us within two (2) calendar days of its decision. We will then notify You within three (3) business days after receiving the reviewer's decision. In the case of a life-threatening condition, the decision must be issued within seventy-two (72) hours after receiving the review request. Except in cases involving a life-threatening condition, the reviewer may request an extension of up to five (5) business days to issue a determination to consider additional information submitted by You or Us.

The reviewer's decision must state the reasons for the determination based upon (1)

the terms of this Certificate; (2) Your medical condition; and (3) information submitted to the reviewer. The reviewer's decision may not expand the terms of Coverage of this Certificate.

Note: No legal action shall be brought to recover under this Certificate until sixty (60) days after proof of loss has been furnished. No such legal action shall be brought more than three (3) years after the time proof of loss is required.

COORDINATION OF BENEFITS

This "Coordination of Benefits" ("COB") provision applies to this Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "this Plan" are defined below.

If this COB provision applies, the order of benefits determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another Plan. The benefits of this Plan:

- Shall not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another Plan; but,
- May be reduced when, under the order of benefits determination rules, another Plan determines its benefits first. The above reduction is described in the subsection "Effect on the Benefits of this Plan".

Definitions

A Plan is any of these which provides benefits or services for, or because of, medical or dental care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practices or individual practice coverage. It also includes coverage other than school accident- type coverage.
- Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX), Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any private insurance program or other non-governmental program.
- Each contract or other arrangement for coverage under the first or second bullet is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.
- For the purposes of coordination of benefits, prescription drug coverage under this plan will be considered a separate Plan and will therefore only be coordinated with other prescription drug coverage.
- This Plan is the part of the group contract that provides benefits for health care expenses.

Primary Plan/Secondary Plan

- The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.
- When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.
- When this Plan is a Secondary Plan, its benefits are determined after those of

the other Plan and may be reduced because of the other Plan's benefits.

- When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Allowable Expense means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

- The difference between the cost of a private hospital room and the cost of a semi- private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.
- When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

Claim Determination Period means a Plan Year. However it does not include any part of a year during which a person has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules

General

When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

- The other plan has rules coordinating its benefits with those of this Plan; and
- Both those rules and this Plan's rules, in the rules section below, require that this Plan's benefits be determined before those of the other Plan.

Rules

This Plan determines its order of benefits using the first of the following rules which applies:

- Non-dependent/dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.
- Dependent child/parents not separated or divorced. Except as stated in subparagraph (III) below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":
    - I. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

- II. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
- III. However, if the other Plan does not have the rules described in (I) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- Dependent child/separated or divorced parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - I. First, the Plan of the parent with custody of the child; and
  - II. Then, the Plan of the spouse of the parent with custody of the child; and
  - III. Finally, the Plan of the parent not having custody of the child.
  - IV. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- Active/inactive employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this bulleted section is ignored.
- Longer/shorter length of coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

Effect on the Benefits of this Plan.

This Section applies when, in accordance with the above section. Order of determination rules, this Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of this Plan or Plans are referred to as "the other Plans" immediately below.

The benefits of this Plan will be reduced when the sum of:

- The benefits that would be payable for the allowable expenses under this Plan in the absence of this COB provision; and
- The benefits that would be payable for the allowable expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those allowable expenses in a claim determination period. In that case, the benefits of this

Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information
Certain facts are needed to apply these COB rules. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give us any facts we need to pay the claim.

Facility of Payment
A payment under another Plan may include an amount which should have been paid under this Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by us is more than it should have paid under this COB provision, we may recover the excess from one or more of:

- The persons we have paid or for whom we have paid;
- Insurance companies; or
- Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

General Coordination of Benefits with Medicare
If you are covered under both Medicare and this certificate, federal law mandates that Medicare is the secondary plan in most situations. When permitted by law, this plan is the secondary plan. In all cases, coordination of benefits with Medicare will conform to federal statutes and regulations. If you are enrolled in Medicare, your benefits under

this certificate will be coordinated to the extent benefits are payable under Medicare, as allowed by federal statutes and regulations.

If you are covered under a Cigna issued individual Certificate and a Cigna-issued small group Certificate, the Cigna-issued small group Certificate is the primary payer.

GENERAL PROVISIONS

Agreements Between Us and Network Providers
Any agreement between Us and Network Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Network Provider or any health benefits program.

Assignment
You or other Members covered under this Certificate may assign any benefits under this Certificate to Your health care Provider. Notice of the assignment must be in writing to Us in order to be effective.

Changes in this Certificate
We may unilaterally change this Certificate upon renewal, if We give You 45 days' prior written notice.

Choice of Law
This Certificate shall be governed by the laws of the State of Georgia.

Clerical Error
Clerical error, whether by You or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Conformity with Law
Any term of this Certificate which is in conflict with Georgia State law or with any applicable federal law that imposes additional requirements from what is required under Georgia State law will be amended to conform with the minimum requirements of such law.

Continuation of Benefit Limitations
Some of the benefits in this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

Continuation of Coverage
If the Plan is discontinued prior to the expiration of the Benefit Period, We may extend health care services to You. Please contact Us at the number on Your ID Card for more information.

Entire Agreement
This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

Furnishing Information and Audit
All persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care.

Identification Cards
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

Incontestability
No statement made by the Subscriber in an application for coverage under this Certificate shall avoid the Certificate or be used in any legal proceeding unless the application or an exact copy is attached to this Certificate. After two (2) years from the date of issue of this Certificate, no misstatements, except for fraudulent misstatements made by the Subscriber in the application for coverage, shall be used to void the Certificate or deny a claim.

Independent Contractors
Network Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Network Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your covered Spouse or Children while receiving care from any Network Provider or in any Network Provider's Facility.

Material Accessibility
We will give You ID cards, Policies, riders and other necessary materials.

More Information About Your Health Plan
You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A copy of Our drug formulary. You may also inquire if a specific drug is

Covered under this Certificate.

- A written description of Our quality assurance program.
- A copy of Our medical Certificate regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with Network Hospitals.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines.
- Written application procedures and minimum qualification requirements for Providers.

Notice

Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: Cigna, c/o Oscar, PO Box 52146 Phoenix, AZ 85072-2146.

Certificate on Third-Party Payment of Cost-Sharing and Premium

The Subscriber is responsible for payment of Premium to Us. We do not accept payment of Premium from any person or entity other than the Subscriber, his or her Dependents, or third-party payors to the extent required by state and federal law. We will review all third-party payments, including payments made by private, not-for-profit foundations, on a case-by-case basis. We may decline to accept third-party payments, including payments by third-party individuals, that raise concerns for potential conflicts of interest, adverse selection, or fraud.

Premium Refund

We will give any refund of Premiums, if due, to the Subscriber.

Recovery of Overpayments

We reserve the right to recover any payments made by Us that were:

- Made in error;
- Made to You or any party on Your behalf, where We determine that such payment made is greater than the amount payable under this Certificate;
- Made to You and/or any party on Your behalf, based on fraudulent or misrepresented information; or
- Made to You and/or any party on Your behalf for charges that were discounted, waived or rebated.

We reserve the right to adjust any amount applied in error to the Deductible or Out- of-Pocket Limit.

We will not conduct a post-payment audit or impose a retroactive denial on a claim that was submitted within 90 days of the last date of service unless:

- We have provided written notice to You of intent to conduct an audit or impose a retroactive denial. Written notice must include reference to the specific claim and reason

for audit or retroactive denial;
- not more than 12 months has elapsed since the last date of service for the claim, prior to the delivery to You of such written notice; and
- any audit or retroactive denial must be completed and notice provided You of any refund or payment due within 18 months of last date of service or discharge covered by such claim.

We may not conduct a post-payment audit or impose a retroactive denial on any claim that was submitted more than 90 days after the last date of service unless:
- We have provided written notice of intent and provided reference to the specific claim and reason for the audit or retroactive denial;
- no more than 12 months has elapsed since the claim was initially submitted by You prior to the delivery to You of such written notice; and
- any audit or retroactive denial must be completed and notice provided to You of any payment or refund due within the sooner of 18 months after Your initial submission of such claim or 24 months after the date of service.

Your Legal Obligations:
An enrollee who is not billed for services by any provider/facility within 45 days of the date the provider/facility knew that payment was due as a result of a post-payment audit or retroactive denial or rejected request to adjust a previously paid claim shall be relieved of any and all legal obligations to respond to a request for additional payment.

Pre-Certification Exception:
When pre-certification has been obtained for a service, the carrier shall be prohibited from contesting, requesting payment, or reopening such claim or any portion thereof at any time following pre-certification except to the extent the insurer is not liable for the payment.

Renewal Date

The renewal date for this Certificate is January 1 of each year. This Certificate will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Certificate or by the Subscriber upon 60 days' prior written notice to Us.

Reinstatement After Default

If the Subscriber defaults in making any payment under this Certificate, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Certificate.

Right to Develop Guidelines and Administrative Rules

We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Examples of the use of the standards are to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

Right to Offset
If We make a premium payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other premiums received, We have the right to subtract any amount You owe Us from any payment We owe You.

Severability
The unenforceability or invalidity of any provision of this Certificate shall not affect the validity and enforceability of the remainder of this Certificate.

Significant Change in Circumstances
If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Network Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Network Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

Conditional Claim Reimbursement
These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition.
We may exercise Our right of reimbursement.
You will notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of any settlement, compromise, judgment or Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which We have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

If, after the inception of coverage with Us, You recover payment from and release any legally responsible person, their insurer, or any uninsured motorist, underinsured motorist, medical payment/expense, Workers' Compensation, no-fault, or other similar insurer from liability for future medical expenses relating to a sickness or bodily injury, We will have a continuing right to reimbursement from You to the extent of the benefits We provided with respect to that sickness or bodily injury. This right, however, will apply only to the extent of such payment and only to the extent not precluded or limited by any law or legal doctrine that prohibits an insurer from seeking reimbursement for its expenses until the insured is made whole.

Third Party Beneficiaries
No third party beneficiaries are intended to be created by this Certificate and nothing in this Certificate shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can

enforce this Certificate's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Evidence of Coverage.

Time to Sue
No action at law or in equity may be maintained against Us prior to the expiration of 60days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within three (3) years from the date the claim was required to be filed.

Translation Services
Translation services are available under this Certificate for non-English speaking Members. Please contact Us at 1-855-672-2789 to access these services.

Venue for Legal Action
If a dispute arises under this Certificate, it must be resolved in a court located in the State of Georgia. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to Georgia courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

Waiver
The waiver by any party of any breach of any provision of this Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

Who May Change this Certificate
This Certificate may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer ("CEO") or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

Who Receives Payment Under this Certificate
Payments under this Policy for services provided by a Network Provider will be made directly by Us to the Provider. If You receive services from a Non-Network Provider, We reserve the right to pay either You or the Provider. See the Assignment section of this Policy for more information about assignment of benefits.

Workers' Compensation Not Affected
The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

Your Medical Records and Reports

In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to
- a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your information with the Georgia quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

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.

References to COBRA apply if your Plan is subject to COBRA.

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, and dental practitioners affiliated or contracted with Us or an organization contracting on Our 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 Us or an organization contracting on Our behalf.

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.

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

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

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special

enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.

- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - 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.

Individuals who enroll in the Plan due to a special enrollment event will not be considered Late Entrants. Any Pre-existing Condition limitation will be applied upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

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

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, 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.

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.

Coverage for Maternity Hospital Stay

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (*e.g.,* your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

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.

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.

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.

Coordination with Medicare

Benefits provided under this plan will not duplicate any benefits paid by Medicare. Determination of the amount payable under this plan will be based upon the difference between the amount paid by Medicare and the Medicare Approved Amount (for Part A) or the Maximum Reimbursable Charge (for Part B).

Eligibility for Medicare

This plan will assume the amount payable under Part A and/or Part B of Medicare for a person who is eligible for but is not currently enrolled in that Part(s), or Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract. A person is considered to be eligible for Medicare on the earliest date any coverage under Medicare could become effective for that person.

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.

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.

FEDERAL REQUIREMENTS

MEDICAL

Claim Determination Procedures for plans subject to 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. We 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, We 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 Our control, We 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 Us within 45 days after receiving the notice. The determination period will be

suspended on the date We send 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, We will make the preservice determination on an expedited basis. We will defer to the determination of the treating health care professional regarding whether an expedited determination is necessary. We 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, We 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 Us within 48 hours after receiving the notice. We 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 Our procedures for requesting a required preservice determination, We 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, We 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, We 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 Our control, We 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 Us within 45 days after receiving the notice. The determination period will be suspended on the date We send 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.

The following applies if your Plan is subject to COBRA.

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 Us;
- after electing COBRA continuation coverage (if applicable), 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 Us 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.

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.

Clinical Trials

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

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

(b) either

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

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

The clinical trial must meet the following requirements:

The study or investigation must:

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

Routine patient care costs are costs associated with the provision of health care items and

services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

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

Routine patient care costs do not include:

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

Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

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

ERISA Required Information, for Plans subject to ERISA

You may contact your employer for the following information:

- Plan Name and Number.
- Employer Name and Employer Identification Number (EIN).
- Name, address, ZIP code and business telephone number of the Plan Sponsor and Administrator.
- Name, address and ZIP code of the person designated as agent for service of legal process.
- The claim office responsible for this Plan, and the office designated to consider the appeal of denied claims.
- The cost of the Plan.
- The Plan's fiscal year end.
- A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.
- 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.

Eligibility Requirements and Benefits

Your certificate sets forth the eligibility requirements and benefits provided for you under this Plan.

Plan Type

The plan is a healthcare benefit plan.

Discretionary Authority

The Plan Administrator delegates to Us 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 Us 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.