

26-1241-cv

United States Court of Appeals *for the* Second Circuit

RICHARD AGAG, MD,

Plaintiff-Appellee,

— v. —

CIGNA HEALTH AND LIFE INSURANCE COMPANY,

Defendant-Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF CONNECTICUT

JOINT APPENDIX Volume 2 of 2 (Pages JA-229 to JA-433)

CLIFFORD A. MERIN
MERIN LAW, LLC
Attorneys for Plaintiff-Appellee
51 Elm Street, Suite 409
New Haven, Connecticut 06510
(475) 321-4101

CAROLINE E. OKS
RYAN P. GOODWIN
STEPHEN R. DONAT
FBT GIBBONS LLP
Attorneys for Defendant-Appellant
One Gateway Center
Newark, New Jersey 07102
(973) 596-4503

(For Continuation of Appearances See Inside Cover)

JAMES GREENSPAN
GOTTLIEB & GREENSPAN, LLC
17-17 Route 208, Suite 250
Fair Lawn, New Jersey 07410
(201) 644-0890

CHARLOTTE TAYLOR
ARIEL VOLPE
JONES DAY
51 Louisiana Avenue, NW
Washington, District of Columbia 20001
(202) 879-3872

– and –

ALEXA BALTES
JONES DAY
110 North Wacker Drive, Suite 4800
Chicago, Illinois 60606
(312) 269-4143

Attorneys for Plaintiff-Appellee

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Caroline E. Oks (ct31928)
Ryan P. Goodwin (*pro hac vice*, phv208932)
Stephen R. Donat (ct31774)
FBT GIBBONS LLP
One Gateway Center
Newark, New Jersey 07102
(973) 596-4500
coks@fbtgibbons.com
rgoodwin@fbtgibbons.com
sdonat@fbtgibbons.com

Attorneys for Defendant
Cigna Health and Life Insurance Company

**UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT**

RICHARD AGAG, MD,

Plaintiff,

v.

CIGNA HEALTH AND LIFE INSURANCE
COMPANY

Defendant.

Civil Action No.: 25-00498-SRU

**CIGNA HEALTH AND LIFE INSURANCE COMPANY'S LOCAL RULE 56(A)2
STATEMENT OF FACTS IN OPPOSITION TO SUMMARY JUDGMENT**

Defendant Cigna Health and Life Insurance Company ("Cigna") submits this Statement of Facts in Opposition to Summary Judgment and Additional Material Facts pursuant to Local Civil Rule 56(a).

1. Plaintiff is a medical provider specializing in plastic and reconstructive surgery. Complaint, ¶ 5; Affidavit of Richard Agag, MD, ¶ 2.

RESPONSE: Undisputed.

2. As an out-of-network provider, Plaintiff does not have a network contract that would determine or limit payment for Plaintiff's services to Defendant's members. Complaint, ¶ 7; Affidavit of Richard Agag, MD, ¶ 4.

RESPONSE: Undisputed.

3. On April 14, 2023, Plaintiff provided medical services for an individual identified as M.L. ("Patient M.L.") at William W. Backus Hospital, a hospital located in Norwich, Connecticut. Complaint, ¶ 13; Affidavit of Richard Agag, MD, ¶ 3. On January 7, 2022, Plaintiff provided medical services for an individual identified as M.P. ("Patient M.P.") at Saint Mary's Hospital, a hospital located in Waterbury, Connecticut. Complaint, ¶ 24; Affidavit of Richard Agag, MD, ¶ 3. (collectively, the "Patients").

RESPONSE: Undisputed.

4. At the time of their treatments, the Patients were each the beneficiaries of health plans issued or administrated by Defendant. Complaint, ¶ 6.

RESPONSE: Undisputed.

5. After treating Patients, Plaintiff submitted Health Insurance Claim Form ("HCFA") medical bills to Defendant seeking payment for the procedures, itemized under Current Procedural Terminology ("CPT") codes as follows:

- a. As to Patient M.L., Plaintiff billed Defendant \$196,000.00 for CPT Code 19364 (Complaint, ¶ 14);
- b. As to Patient M.P., Plaintiff billed Defendant:
 - i. \$9,226.40 for CPT code 35703 LT (Complaint, ¶ 25);
 - ii. \$9,226.40 for CPT code 35703 RT (Complaint, ¶ 35);

- iii. \$7,700.00 for CPT code 15002 (Complaint, ¶ 45); and
- iv. \$31,752.40 for CPT code 32900 (Complaint, ¶ 55). *See* Affidavit of Richard Agag, MD, ¶ 5-6.

RESPONSE: Undisputed.

6. In response to Plaintiff's HCFAs, Defendant denied payment for both Patients. Complaint, ¶ 15, 26, 36, 46, 56; Affidavit of Richard Agag, MD, ¶ 7.

RESPONSE: Undisputed insofar as Cigna denied CPT code 19364 based on medical necessity and CPT codes 35703 LT, 35703 RT, 15002, and 32900 based on timeliness. Declaration of Jose Farias ("Farias Decl."), ¶¶ 8-9, 19-20, Exs. B, D.

7. Plaintiff is out-of-network with Defendant and Patients' health plans ordinarily do not include coverage for out-of-network treatments. Complaint, ¶ 7.

RESPONSE: Undisputed that Plaintiff is out-of-network with Cigna. Disputed that Patients' health plans ordinarily do not include coverage for out-of-network treatments. *See, e.g.*, Farias Decl. Ex. A at 15; Ex. C at 14.

8. Since the services were rendered emergently/inadvertently, Patients' out-of-network medical treatments are subject to reimbursement pursuant to the No Surprises Act (the "NSA"). Complaint, ¶ 8.

RESPONSE: Disputed. Cigna objects to this statement on the grounds that "Patients' out-of-network medical treatments are subject to reimbursement pursuant to the [NSA]" constitutes a legal conclusion rather than a factual assertion, contrary to L. Civ. R. 56(a)(1), and is not supported by admissible evidence. Further, the claims were not subject to the NSA because they involved coverage determinations. *See* 42 U.S.C. § 300gg-111(a)(1), (b)(1)(C); 45 C.F.R. § 149.120(c)(3)(i); *see also* Farias Decl. ¶¶ 8-9, 19-20.

9. Pursuant to the NSA, an out-of-network provider reserves the right to dispute a health plan's reimbursement for qualifying out-of-network services and initiate a 30-day negotiation period. Complaint, ¶ 9.

RESPONSE: Disputed. Cigna objects to this statement on the grounds that it constitutes a legal conclusion rather than a factual assertion, contrary to L. Civ. R. 56(a)(1), and is not supported by admissible evidence. Undisputed insofar as the NSA establishes a non-judicial dispute resolution process when an out-of-network provider and payor cannot agree on payment for the medical care rendered by the provider to a protected patient. Under the NSA, the out-of-network provider must first submit its claim directly to the insured's health plan. Within thirty (30) days of receipt, the payer must render an initial payment or issue a notice of denial to the provider. *See* 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I), (b)(1)(C)–(D)

10. Plaintiff disputed Defendant's payment determinations and initiated the negotiation period called for by the NSA. Complaint, ¶ 16, 27, 37, 47, 57.

RESPONSE: Disputed that Cigna made "payment determinations." Cigna determined that Claim No. 4682328298918 was not eligible for coverage under Patient M.L.'s benefits plan because the services identified on that out-of-network claim were not medically necessary. Farias Decl. ¶¶ 8–9, Ex. B. Cigna determined that Claim No. 4682422201002 was not eligible for coverage under Patient M.P.'s benefits plan because that out-of-network claim was submitted too late. *Id.* ¶¶ 19–20, Ex. D.

11. Pursuant to the NSA, if the payment dispute between the provider and carrier is not resolved during the negotiation period, the provider has the right to initiate arbitration under which the proper reimbursement amount is determined by a neutral arbitrator. Complaint, ¶ 10.

RESPONSE: Disputed. Cigna objects to this statement on the grounds that it constitutes a legal conclusion rather than a factual assertion, contrary to L. Civ. R. 56(a)(1), and is not supported by admissible evidence. The NSA does not afford a provider a right to initiate arbitration proceedings. When an out-of-network provider is dissatisfied with the payment, if any, it received from a payer, the provider may attempt to negotiate with the payor on an agreed-upon payment rate for the relevant services. If open negotiations fail and the negotiation period is exhausted, the provider or the payor may initiate the Independent Dispute Resolution ("IDR") process. Under the IDR process, the parties select, or the Department of Health and Human Resources appoints, a certified IDR Entity ("CIDRE") to resolve the dispute and make a payment determination. 42 U.S.C. § 300gg-111(c)(1), (c)(1)(B), (c)(4)(F), (c)(5).

12. Plaintiff initiated five arbitrations called for by the NSA (Complaint, ¶ 17, 28, 38, 48, 58) which were decided by the certified independent dispute resolution entity (“CIDRE”) assigned to each arbitration, as follows:

- a. On March 6, 2024, CIDRE Federal Hearings and Appeals Service, Inc., ruled in Plaintiff’s favor under Arbitration Dispute DISP-878778, awarding Plaintiff a total of \$97,500.00 for CPT code 19364. *See Exhibit A to Complaint*, attached hereto. *See* Affidavit of Richard Agag, MD, ¶ 8.
- b. On December 19, 2024, CIDRE ProPeer Resources, LLC (“ProPeer”), ruled in Plaintiff’s favor under Arbitration Dispute DISP-2001877, awarding Plaintiff a total of \$5,535.84 for CPT code 35703 LT. *See Exhibit B to Complaint*, attached hereto. *See* Affidavit of Richard Agag, MD, ¶ 9.
- c. On December 19, 2024, ProPeer ruled in Plaintiff’s favor under Arbitration Dispute DISP-2001876, awarding Plaintiff a total of \$5,535.84 for CPT code 35703 RT. *See Exhibit C to Complaint*, attached hereto. *See* Affidavit of Richard Agag, MD, ¶ 10.
- d. On December 19, 2024, ProPeer ruled in Plaintiff’s favor under Arbitration Dispute DISP-2001874, awarding Plaintiff a total of \$7,700.00 for CPT code 15002. *See Exhibit D to Complaint*, attached hereto. *See* Affidavit of Richard Agag, MD, ¶ 11.
- e. On December 19, 2024, ProPeer ruled in Plaintiff’s favor under Arbitration Dispute DISP-2001871, awarding Plaintiff a total of \$26,296.31 for CPT code 32900. *See Exhibit E to Complaint*, attached hereto. *See* Affidavit of Richard Agag, MD, ¶ 12.

RESPONSE: Disputed. The NSA provides for an IDR process and does not afford an out-of-network medical provider a right to initiate arbitration proceedings. *See Freeman Pain Inst. P.A. d/b/a Redefine Health v. Horizon Blue Cross Blue Shield of N. J.*, No. 25-02507 (SRC), 2025 U.S. Dist. LEXIS 230402, at *11 (D.N.J. Nov. 24, 2025) (“[T]he very nature of the IDR process is too different from a traditional arbitration as contemplated by the FAA for this Court to find that Congress intended for the FAA to govern the IDR process.”); *Mod. Orthopaedics of NJ v. Premera Blue Cross*, No. 25-1087 (BRM), 2025 U.S. Dist. LEXIS 215824, at *17 (D.N.J. Nov. 3, 2025) (“[T]he IDR process is far too different from arbitration for this Court to conclude that Congress implied for the FAA to govern the IDR process in general.”).

13. Pursuant to the NSA, if it is determined in arbitration that an additional amount remains due, the insurer has 30 days from the date of the arbitration award to issue the additional payment. Complaint, ¶ 11, 20, 31, 41, 51.

RESPONSE: Disputed. Cigna objects to this statement on the grounds that it constitutes a legal conclusion rather than a factual assertion, contrary to L. Civ. R. 56(a)(1), and is not supported by admissible evidence.

14. Defendant has not issued any of the award payments to Plaintiff. Complaint, ¶ 65. Affidavit of Richard Agag, MD, ¶ 13.

RESPONSE: Undisputed.

15. As of November 21, 2025, more than 606 days have elapsed since the date of the award pursuant to DISP-878778.

RESPONSE: Undisputed.

16. As of November 21, 2025, more than 300 days have elapsed since the awards were entered in DISP-2001877, DISP-2001876, DISP-2001874, and DISP-2001871.

RESPONSE: Undisputed.

ADDITIONAL MATERIAL FACTS

A. Patient M.L.

1. Patient M.L.'s benefits under her health benefits plan are set forth in the plan's Summary Plan Description ("SPD"). Farias Decl. ¶ 3, Ex. A. As stated in the SPD, the plan only provides reimbursement for services covered under the terms of the plan. *See id.* ¶ 4, Ex. A at 58.

2. For example, to determine whether health care services are medically necessary, Cigna typically requires clinical, administrative, and policy-based information from the medical provider. Upon receipt of such requested information, Cigna is able to compare the proposed treatment against established medical standards and determine whether the proposed treatment is appropriate, evidence-based, not primarily for convenience, and consistent with the member's condition and policy terms. *See id.* ¶ 4, Ex. A at 69.

3. On October 9, 2023, following Patient M.L.'s April 14, 2023, medical services, Cigna received a claim in the amount of \$196,000.00 for CPT code 19364 from Plaintiff, which Cigna identified as Claim No. 4682328298918. *See id.* ¶ 6.

4. On October 25, 2023, Cigna processed Claim No. 4682328298918 and issued an EOB, which it sent to Plaintiff. *See id.* ¶ 7, Ex. B.

5. Cigna denied Plaintiff's claim for CPT code 19364 for the following reason: "Based on the information we have available, the services or supplies on this claim are not medically necessary." *See id.* ¶ 8, Ex. B at 3.

6. Cigna's denial of CPT code 19364 relates to coverage, not reimbursement. *See id.* ¶ 9.

7. Cigna never sent Plaintiff an initial payment or issued a notice of denial of payment for Claim No. 4682328298918 because Claim No. 4682328298918 was determined to be ineligible for coverage. *See id.* ¶ 10.

8. 386 days passed between CIDRE Federal Hearings and Appeals Service, Inc.'s March 6, 2024, IDR determination for DISP-878778 and Plaintiff's March 27, 2025, Complaint (ECF No. 1). *See id.* ¶ 12.

Patient M.P.

9. Patient M.P.'s benefits under her health benefits plan are set forth in the plan's Summary Plan Description ("SPD"). *See id.* ¶ 13, Ex. C. As stated in the SPD, the plan only provides reimbursement for services covered under the terms of the plan. *See generally id.*, Ex. C.

10. For example, in order for a claim to be covered under the terms of the plan, it must be submitted within 180 days after services are rendered. *See id.* ¶ 14, Ex. C at 10. If such claims are not submitted within 180 days, Cigna will not consider them and they will be denied. *See id.* ¶ 14, Ex. C at 10.

11. On August 9, 2024, following Patient M.P.'s January 7, 2022, medical services, Cigna received a claim in the amount of \$45,067.99 for CPT codes 35703 LT, 35703 RT, 15002, and 32900 from Plaintiff, which Cigna identified as Claim No. 4682422201002. *See id.* ¶ 16, Ex. D at 3.

12. 945 days passed between Patient M.P.'s date of service and Plaintiff's submission of Claim No. 4682422201002. *See id.* ¶ 17.

13. On August 24, 2024, Cigna processed Claim No. 4682422201002 and issued an EOB, which it sent to both Patient M.P. and Plaintiff. *See id.* ¶ 18, Ex. D at 3.

14. Cigna denied Plaintiff's claim for CPT codes 35703 LT, 35703 RT, 15002, and 32900 for the following reason: "This out-of-network claim was sent too late. Therefore, the claim was denied and you must pay the claim. If you have proof that you sent it on time, please resubmit the claim along with the proof to the address on the back of your CIGNA ID card. For more information on claim-filing deadlines please refer to your plan booklet." *See id.* ¶ 19, Ex. D at 3.

15. Cigna's denial of CPT codes 35703 LT, 35703 RT, 15002, and 32900 relate to coverage, not reimbursement. *See id.* ¶ 20, Ex. D at 3.

16. Cigna never sent Plaintiff an initial payment or issued a notice of denial of payment for Claim No. 4682422201002.

Dated: January 12, 2026
Newark, New Jersey

s/ Caroline E. Oks
Caroline E. Oks (ct31928)
Ryan P. Goodwin (*pro hac vice*, phv208932)
Stephen R. Donat (ct31774)
FBT GIBBONS LLP
One Gateway Center
Newark, New Jersey 07102
(973) 596-4500
coks@fbtgibbons.com
rgoodwin@fbtgibbons.com
sdonat@fbtgibbons.com

Attorneys for Defendant
Cigna Health and Life Insurance Company

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

RICHARD AGAG, MD,

Plaintiff,

v.

CIGNA HEALTH AND LIFE INSURANCE
COMPANY,

Defendant.

Civil Action No. 25-498-SRU

Document electronically filed

**DECLARATION OF JOSE FARIAS IN OPPOSITION TO PLAINTIFF RICHARD
AGAG, MD'S CROSS-MOTIONS TO CONFIRM AND FOR SUMMARY JUDGMENT**

I, **Jose Farias**, hereby declare as follows:

1. I am employed by Defendant Cigna Health and Life Insurance Company ("Cigna") as a Senior Supervisor in Cigna's Out of Network Protection Team, Provider Contracting Division.

2. I submit this Declaration in opposition to Plaintiff Richard Agag, MD's ("Plaintiff") Cross-Motions to Confirm and for Summary Judgment. I make this declaration based upon my knowledge of Cigna's relevant business practices.

Patient M.L.

3. Patient M.L.'s benefits under her health benefits plan are set forth in the plan's Summary Plan Description ("SPD"). Attached hereto as **Exhibit A** is a true and correct copy of the SPD for Patient M.L.'s health benefits plan.

4. As stated in the SPD, her plan only provides reimbursement for services covered under its terms. *See, e.g.*, Ex. A at 58. To determine whether health care services are medically necessary, Cigna typically requires clinical, administrative, and policy-based information from the medical provider. Upon receipt of such information, Cigna is able to compare the proposed

treatment against established medical standards to determine whether the proposed treatment is appropriate, evidence-based, not primarily for convenience, and consistent with the member's condition and policy terms. *See id.* at 69.

5. Attached hereto as **Exhibit B** is a true and correct copy of Cigna's Explanation of Benefits ("EOB") for Patient M.L.'s April 14, 2023, medical services.

6. On October 9, 2023, Cigna received a claim in the amount of \$196,000.00 for CPT Code 19364 from Plaintiff for the April 14, 2023, medical services performed on Patient M.L., which Cigna identified as Claim No. 4682328298918. *See Ex. B* at 3.

7. On October 25, 2023, Cigna processed Claim No. 4682328298918 and issued the EOB, which it sent to Plaintiff. *See id.*

8. Cigna denied Plaintiff's claim for CPT code 19364 for the following reason: "Based on the information we have available, the services or supplies on this claim are not medically necessary." *Id.*

9. Cigna's denial of CPT code 19364 relates to coverage, not reimbursement. *See id.* ("Based on the information we have available, the services or supplies on this claim are not medically necessary.").

10. Cigna never sent Plaintiff an initial payment or issued a notice of denial of payment for CPT code 19364 because Claim No. 4682328298918 was determined to be ineligible for coverage. *See id.*

11. Claim No. 4682328298918 is addressed in the IDR proceeding identified as DISP-878778 for CPT code 19364.

12. 386 days passed between the March 6, 2024, IDR determination for DISP-878778 and Plaintiff's March 27, 2025 Complaint.

Patient M.P.

13. Patient M.P.'s benefits under her health benefits plan are set forth in the plan's SPD. Attached hereto as **Exhibit C** is a true and correct copy of the SPD for Patient M.P.'s health benefits plan.

14. As stated in her SPD, in order for a claim for reimbursement to be covered under the terms of the plan, it must be submitted within a certain time frame. *See* Ex. C at 10. Cigna will consider claims for out-of-network coverage when submitted within 180 days after services are rendered. *See id.* If such claims are not submitted within 180 days, Cigna will not consider them and they will be denied. *See id.*

15. Attached hereto as **Exhibit D** is a true and correct copy of Cigna's EOB for Patient M.P.'s January 7, 2022, medical services.

16. On August 9, 2024, Cigna received a claim in the amount of \$45,067.99 for CPT codes 35703 LT, 35703 RT, 15002, and 32900 from Plaintiff for the January 7, 2022, medical services performed on Patient M.P., which Cigna identified as Claim No. 4682422201002. *See* Ex. D at 3.

17. 945 days passed between Patient M.P.'s date of service and Plaintiff's submission of Claim No. 4682422201002. *See id.*

18. On August 24, 2024, Cigna processed Claim No. 4682422201002 and issued the EOB, which it sent to Plaintiff. *See id.*

19. Cigna denied Plaintiff's claim for CPT codes 35703 LT, 35703 RT, 15002, and 32900 for the following reason: "This out-of-network claim was sent too late. Therefore, the claim was denied and you must pay the claim. If you have proof that you sent it on time, please resubmit

the claim along with the proof to the address on the back of your CIGN ID card. For more information on claim-filing deadlines please refer to your plan booklet.” *Id.*

20. Cigna’s denial of CPT codes 35703 LT, 35703 RT, 15002, and 32900 relate to coverage, not reimbursement. *See id.* (“This out-of-network claim was sent too late. Therefore, the claim was denied and you must pay the claim. If you have proof that you sent it on time, please resubmit the claim along with the proof to the address on the back of your CIGN ID card. For more information on claim-filing deadlines please refer to your plan booklet.”).

21. Cigna never sent Plaintiff an initial payment or issued a notice of denial of payment for CPT codes 35703 LT, 35703 RT, 15002, and 32900 because Claim No. 4682422201002 was determined to be ineligible for coverage. *See id.*

22. Claim No. 4682422201002 is addressed in the following IDR proceedings:

- i. DISP-2001871 for CPT code 32900-RT;
- ii. DISP-2001874 for CPT code 15002;
- iii. DISP-2001876 for CPT code 35703-RT; and
- iv. DISP-2001877 for CPT code 35703-LT.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

Dated: January 12, 2026



Jose Farias

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Exhibit A

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**Town of Manchester and
Manchester BOE**

OPEN ACCESS PLUS MEDICAL
BENEFITS

Plus \$5 - \$75 ER Copay

EFFECTIVE DATE: July 1, 2020

ASO152
3329502

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

Printed in U.S.A.

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Important Information

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

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

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Explanation of Terms

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

The Schedule

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



Special Plan Provisions

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

Services Available in Conjunction With Your Medical Plan

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

HC-SPP44

04-17

Case Management

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

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

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

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

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Additional Programs

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



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

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Care Management and Care Coordination Services

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

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Important Notices

Direct Access to Obstetricians and Gynecologists

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

Selection of a Primary Care Provider

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

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

HC-NOT5

01-11

Important Information

Rebates and Other Payments

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

Coupons, Incentives and Other Communications

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

HC-IMP258

01-19

Discrimination is Against the Law

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

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters



- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as
 - Qualified interpreters
 - Information written in other languages

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

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

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

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

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

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

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Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

**Japanese –**

注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711) まで、お電話にてご連絡ください。

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

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

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

HC-NOT97

07-17

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

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

Non-Quantitative Treatment Limitations (NQTLs) include:

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

- Exclusions and/or restrictions based on geographic location, facility type or provider specialty.

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

Employers (Plan Administrators):

<https://cignaaccess.cigna.com/secure/app/ca/centralRepo> - Log in, select Resources and Training, then select the NQTL document.

Covered Persons: www.cigna.com/sp

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

HC-NOT113

01-20

How To File Your Claim

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

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

CLAIM REMINDERS

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

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

YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.



Timely Filing of Out-of-Network Claims

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

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

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Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work a specified number of hours per week as determined by collective bargaining; and
- you pay any required contribution as determined by collective bargaining agreement.

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

Eligibility for Dependent Insurance

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

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

Waiting Period

The first day of the month following date of hire.

Classes of Eligible Employees

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

Effective Date of Employee Insurance

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

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

Late Entrant - Employee

You are a Late Entrant if:

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

Dependent Insurance

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

Effective Date of Dependent Insurance

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

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

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

Exception for Newborns

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

HC-ELG274 M

01-19



Important Information About Your Medical Plan

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

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

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

Changing Primary Care Physicians:

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

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



Open Access Plus Medical Benefits The Schedule
For You and Your Dependents Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance. When you receive services from an In-Network Provider, remind your provider to utilize In-Network Providers for x-rays, lab tests and other services to ensure the cost may be considered at the In-Network level. If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.
Coinsurance The term Coinsurance means the percentage of Covered Expenses that an insured person is required to pay under the plan in addition to the Deductible, if any. Copayments/Deductibles Copayments are amounts to be paid by you or your Dependent for covered services. Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this plan. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.
Out-of-Pocket Expenses - For In-Network Charges Only Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in The Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.
Out-of-Pocket Expenses - For Out-of-Network Charges Only Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%: • Coinsurance. • Plan Deductible. • Any copayments and/or benefit deductibles. Once the Out-of-Pocket Maximum is reached for covered services that apply to the Out-of-Pocket Maximum, any copayments and/or benefit deductibles are no longer required. The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached: • Non-compliance penalties. • Provider charges in excess of the Maximum Reimbursable Charge.

JA-256



Open Access Plus Medical Benefits

The Schedule

Accumulation of Plan Out-of-Pocket Maximums

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

Multiple Surgical Reduction

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

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

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

Co-Surgeon

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

Out-of-Network Emergency Services Charges

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

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

BENEFIT HIGHLIGHTS		IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited		
The Percentage of Covered Expenses the Plan Pays	100%	80% of the Maximum Reimbursable Charge	
Note: "No charge" means an insured person is not required to pay Coinsurance.			



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maximum Reimbursable Charge Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A policyholder-selected percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: - the provider's normal charge for a similar service or supply; or - the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Note: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance. Note: Some providers forgive or waive the cost share obligation (e.g. your copayment, deductible and/or coinsurance) that this plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this plan. For more details, see the Exclusions Section.	Not Applicable	300%

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible Individual Family Maximum Family Maximum Calculation Individual Calculation: Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.	Not Applicable Not Applicable	\$250 per person \$750 per family
Out-of-Pocket Maximum Individual Family Maximum Family Maximum Calculation Individual Calculation: Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.	\$5,100 per person \$10,200 per family	\$1,500 per person \$4,500 per family

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services Primary Care Physician's Office Visit Specialty Care Physician's Office Visits Consultant and Referral Physician's Services Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company. Surgery Performed in the Physician's Office Second Opinion Consultations (provided on a voluntary basis) Allergy Treatment/Injections Allergy Serum (dispensed by the Physician in the office)	No charge after \$5 per office visit copay No charge after \$5 Specialist per office visit copay No charge No charge after the \$5 PCP or \$5 Specialist per office visit copay No charge No charge	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible
Virtual Care Dedicated Virtual Providers Services available through contracted virtual providers as medically appropriate. Virtual Care Services for minor medical conditions	No charge after the \$5 PCP per office visit copay	In-Network coverage only
Preventive Care Note: Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit. Routine Preventive Care - all ages Immunizations - all ages (Includes travel)	No charge No charge	80% after plan deductible 80% after plan deductible
Mammograms, PSA, PAP Smear Preventive Care Related Services (i.e. "routine" services) Diagnostic Related Services (i.e. "non-routine" services)	No charge Subject to the plan's x-ray & lab benefit; based on place of service	80% after plan deductible Subject to the plan's x-ray & lab benefit; based on place of service

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital - Facility Services	100%	80% after plan deductible
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	100%	80% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	100%	80% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	100%	80% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	100%	80% after plan deductible
Urgent Care Services Physician's Office Visit Urgent Care Facility or Outpatient Facility Outpatient Professional Services (radiology, pathology, physician) X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit) Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	No charge after the \$5 PCP or \$5 Specialist per office visit copay No charge after \$25 per visit copay* *waived if admitted No charge No charge No charge	No charge after the \$5 PCP or \$5 Specialist per office visit copay No charge after \$25 per visit copay* *waived if admitted No charge No charge No charge

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency Services Physician's Office Visit Hospital Emergency Room Outpatient Professional Services (radiology, pathology, ER physician) X-ray and/or Lab performed at the Emergency Room Facility (billed by the facility as part of the ER visit) Independent X-ray and/or Lab Facility in conjunction with an ER visit Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	No charge after the \$5 PCP or \$5 Specialist per office visit copay No charge after \$75 per visit copay* *waived if admitted No charge No charge No charge No charge	No charge after the \$5 PCP or \$5 Specialist per office visit copay No charge after \$75 per visit copay* *waived if admitted No charge No charge No charge No charge
Ambulance	100%	100%
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 180 days combined	100%	80% after plan deductible
Laboratory Services (includes pre-admission testing) Physician's Office Visit Outpatient Hospital Facility Independent X-ray and/or Lab Facility Note: Non Par Labs paid and Independent Lab places of service. This heading applies to both preventive and diagnostic services for both par and non-par services.	No charge after the \$5 PCP or \$5 Specialist per office visit copay 100% 100%	80% after plan deductible 80% after plan deductible 80% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Radiology Services (includes pre-admission testing) Physician's Office Visit Outpatient Hospital Facility Independent X-ray and/or Lab Facility	No charge after the \$5 PCP or \$5 Specialist per office visit copay 100% 100%	80% after plan deductible 80% after plan deductible 80% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans) Physician's Office Visit Inpatient Facility Outpatient Facility	No charge 100% 100%	80% after plan deductible 80% after plan deductible 80% after plan deductible
Outpatient Therapy Services and Chiropractic Services Calendar Year Maximum: 60 days for all therapies combined (The limit is not applicable to mental health conditions.) Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Chiropractic Therapy (includes Chiropractors)	No charge after the \$5 PCP or \$5 Specialist per office visit copay Note: Outpatient Therapy Services copay applies, regardless of place of service, including the home.	80% after plan deductible
Outpatient Cardiac Rehabilitation Calendar Year Maximum: 36 days per occurrence	No charge after the \$5 Specialist per office visit copay	80% after plan deductible
Home Health Care Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)	100%	80% after plan deductible
Hospice Inpatient Services Outpatient Services (same coinsurance level as Home Health Care)	100% 100%	80% after plan deductible 80% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Bereavement Counseling Services provided as part of Hospice Care Inpatient Outpatient Services provided by Mental Health Professional	100% 100% Covered under Mental Health benefit	80% after plan deductible 80% after plan deductible Covered under Mental Health benefit
Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary. Gene therapy must be received at an In-Network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other In-Network facilities is not covered. Gene Therapy Product Inpatient Facility Outpatient Facility Physician's Services Travel Maximum: \$10,000 per episode of gene therapy	Subject to In-Network facility cost share based on place of service; separate from facility charges 100% 100% 100% No charge (available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy)	In-Network coverage only In-Network coverage only In-Network coverage only In-Network coverage only In-Network coverage only

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services Initial Visit to Confirm Pregnancy Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company. All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee) Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist Delivery - Facility (Inpatient Hospital, Birthing Center)	No charge after the \$5 PCP or \$5 Specialist per office visit copay 100% No charge after the \$5 PCP or \$5 Specialist per office visit copay 100%	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible
Abortion Includes elective and non-elective procedures Physician's Office Visit Surgery Performed in the Physician's Office Inpatient Facility Outpatient Facility Physician's Services	No charge after the \$5 PCP or \$5 Specialist per office visit copay 100% 100% 100% 100%	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Women's Family Planning Services Office Visits, Lab and Radiology Tests and Counseling Note: Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office. Surgical Sterilization Procedures for Tubal Ligation (excludes reversals) Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	No charge No charge No charge No charge No charge	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible
Men's Family Planning Services Office Visits, Lab and Radiology Tests and Counseling Surgical Sterilization Procedures for Vasectomy (excludes reversals) Physician's Office Visit Surgery Performed in the Physician's Office Inpatient Facility Outpatient Facility Physician's Services	No charge after the \$5 PCP or \$5 Specialist per office visit copay No charge after the \$5 PCP or \$5 Specialist per office visit copay 100% 100% 100% 100%	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Infertility Services Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination, In-vitro, GIFT, ZIFT, etc.		
Physician's Office Visit (Lab and Radiology Tests, Counseling) Inpatient Facility Outpatient Facility Physician's Services Lifetime Maximum: \$5,000 per member Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).	No charge after the \$5 PCP or \$5 Specialist per office visit copay 100% 100% 100%	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible
Organ Transplants Includes all medically appropriate, non-experimental transplants Physician's Office Visit Inpatient Facility Physician's Services Lifetime Travel Maximum: \$10,000 per transplant	No charge after the \$5 PCP or \$5 Specialist per office visit copay 100% at LifeSOURCE center, otherwise 100% 100% at LifeSOURCE center, otherwise 100% No charge (only available when using LifeSOURCE facility)	80% after plan deductible 80% after plan deductible 80% after plan deductible In-Network coverage only
Durable Medical Equipment Calendar Year Maximum: Unlimited	100%	80% after plan deductible
Breast Feeding Equipment and Supplies Note: Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	No charge	80% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
External Prosthetic Appliances Calendar Year Maximum: Unlimited	100%	80% after plan deductible
Nutritional Evaluation Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of mental health and substance use disorder conditions. Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	No charge after the \$5 PCP or \$5 Specialist per office visit copay 100% 100% 100%	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible
Genetic Counseling Calendar Year Maximum: 3 visits per person for Genetic Counseling for both pre- and post-genetic testing; however, the 3 visit limit will not apply to Mental Health and Substance Use Disorder conditions. Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	No charge after the \$5 PCP or \$5 Specialist per office visit copay 100% 100% 100%	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to teeth. Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services	No charge after the \$5 PCP or \$5 Specialist per office visit copay 100% 100% 100%	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Acupuncture Maximum: 20 per Calendar Year	No charge after the \$5 per visit copay	80% after plan deductible
Eye Care Services Maximum: 1 eye exam every 24 months Note: Covers refractions for routine and medical diagnosis	100%	100%
Hearing Aids Calendar Year Maximum: \$1,000 for children through age 12	100%	80% after plan deductible
Naturopath Services	No charge after the \$5 per visit copay	No charge after the \$5 per visit deductible
Nutritional Supplements Note: For children through age 12. Includes coverage for Nutritional Formula.	100%	100%
Osteopath Services	No charge after the \$5 per visit copay	No charge after the \$5 per visit deductible
Wigs Calendar Year Maximum: \$350	100%	100%
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health Inpatient Includes Acute Inpatient and Residential Treatment Calendar Year Maximum: Unlimited Outpatient Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc. Calendar Year Maximum: Unlimited	100% \$5 per visit copay 100%	80% after plan deductible 80% after plan deductible 80% after plan deductible
Substance Use Disorder Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Calendar Year Maximum: Unlimited Outpatient Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc. Calendar Year Maximum: Unlimited	100% \$5 per visit copay 100%	80% after plan deductible 80% after plan deductible 80% after plan deductible



Open Access Plus Medical Benefits

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

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

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 72 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will be reduced by the lesser of 50% or \$250 for Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 72 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will be reduced by the lesser of 50% or \$250:

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

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

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

Outpatient Certification Requirements – Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and

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

Covered Expenses incurred will be reduced by the lesser of 50% or \$250 for charges made for any outpatient diagnostic testing or outpatient procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will be reduced by the lesser of 50% or \$250 for charges made for outpatient diagnostic testing or outpatient procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

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

Outpatient Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

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

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01-19

Prior Authorization/Pre-Authorized

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



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

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

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Covered Expenses

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

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

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

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.

- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for family planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges made for the following preventive care services (detailed information is available at www.healthcare.gov):
 - (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
 - (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the covered person involved;
 - (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;



- (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- charges made for acupuncture.
 - charges made for hearing aids, for children through age 12, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
 - charges for the delivery of real-time medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.
 - behavioral consultations and services via secure telecommunications technologies that shall include video capability, including telephones and internet, when delivered through a behavioral provider.

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

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

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

Genetic Testing

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

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

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



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

Nutritional Evaluation and Counseling

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

Internal Prosthetic/Medical Appliances

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

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Orthognathic Surgery

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

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

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Home Health Services

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

Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided

for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

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

HC-COV863

01-20

Hospice Care Services

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



- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

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

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

HC-COV6

04-10
V1

Mental Health and Substance Use Disorder Services

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

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

Inpatient Mental Health Services

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

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

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

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

Outpatient Mental Health Services

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

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

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

Inpatient Substance Use Disorder Rehabilitation Services

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

Substance Use Disorder Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional



disturbances that are a result of subacute Substance Use Disorder conditions.

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

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

Outpatient Substance Use Disorder Rehabilitation Services

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

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

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

Substance Use Disorder Detoxification Services

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

Exclusions

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

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

HC-COV481

12-15

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

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

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

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized),



patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.

- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

HC-COV8

04-10
v2

External Prosthetic Appliances and Devices

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

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

Prostheses/Prosthetic Appliances and Devices

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

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

Orthoses and Orthotic Devices

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

- Non-foot orthoses – only the following non-foot orthoses are covered:
 - rigid and semi-rigid custom fabricated orthoses;
 - semi-rigid prefabricated and flexible orthoses; and

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

The following are specifically excluded orthoses and orthotic devices:

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

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

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

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.



- replacement required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Coverage for replacement is limited as follows:

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

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

HC-COV732

01-19

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and the services of an embryologist.

Infertility is defined as:

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

month period of time, when the female partner trying to conceive is age 35 or older.

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

However, the following are specifically excluded infertility services:

- reversal of male and female voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges and services;
- cryopreservation of donor sperm and eggs; and
- any experimental, investigational or unproven infertility procedures or therapies.

HC-COV734

01-19

Outpatient Therapy Services

Charges for the following therapy services:

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

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

Cardiac Rehabilitation

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

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

Chiropractic Care Services

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



Coverage is provided:

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

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

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

Therapy services that are not covered include:

- sensory integration therapy;
- treatment of dyslexia;
- charges for Chiropractic Care not provided in an office setting; or
- vitamin therapy.

Coverage is administered according to the following:

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

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

HC-COV864 M

01-20

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy, if the insured chooses to have surgery, and in

the manner chosen by the insured and Physician. Services and benefits include:

- surgical services for reconstruction of the breast on which surgery was performed;
- surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
- postoperative breast prostheses; and
- mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy are covered.

Cosmetic Surgery

Charges made for cosmetic surgery or therapy to repair or correct severe facial disfigurements or severe physical deformities that are congenital or result from developmental abnormalities (other than abnormalities of the jaw or TMJ disorder), tumors, trauma, disease or the complications of Medically Necessary non-cosmetic surgery.

Reconstructive surgery for correction of congenital birth defects or developmental abnormalities must be performed prior to your attainment of age 19. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by Cigna.

HC-COV631

12-17

Transplant Services

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

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

All Transplant services, other than cornea, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at 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 In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are covered at the Out-of-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.

Transplant Travel Services

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

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

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

HC-COV482

12-15

Medical Pharmaceuticals

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

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

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

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



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

HC-COV526

10-16

Gene Therapy

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

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

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

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

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

Gene Therapy Travel Services

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

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

is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

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

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

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

HC-COV873

01-20

JA-281



Prescription Drug Benefits The Schedule	
For You and Your Dependents	
This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a Deductible, Copayment or Coinsurance requirement for Covered Expenses for Prescription Drug Products.	
Coinsurance	
The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.	
Copayments (Copay)	
Copayments are amounts to be paid by you or your Dependent for covered Prescription Drug Products.	



BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Patient Assurance Program Your plan offers additional discounts for certain covered Prescription Drug Products that are dispensed by a retail or home delivery Network Pharmacy included in what is known as the “Patient Assurance Program”. As may be described elsewhere in this plan, from time to time Cigna may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your Out-of-Pocket Expenses for certain covered Prescription Drug Products for which Cigna directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna for certain covered Prescription Drug Products included in the Patient Assurance Program is applied or credited to a portion of your Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drug Products as set forth in The Schedule may be reduced in order for Patient Assurance Program discounts earned by Cigna to be applied or credited to the Copayment or Coinsurance, if any, as described above. For example, certain insulin product(s) covered under the Prescription Drug Benefit for which Cigna directly or indirectly earns a discount in connection with the Patient Assurance Program shall result in a credit toward some or all of your Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in The Schedule, for the insulin product. In addition, the covered insulin products eligible for Patient Assurance Program discounts shall not be subject to the Deductible, if any. Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-Of-Pocket Maximum. Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum. Please note that the Patient Assurance Program discounts that Cigna may earn for Prescription Drug Products, and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any rebates or other payments that Cigna may earn from a pharmaceutical manufacturer for the same or other Prescription Drug Products. Except as may be noted elsewhere in this plan, you are not entitled to the benefit of those rebates or other payments earned by Cigna because they are unrelated to the Patient Assurance Program. Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drug Products included in the Patient Assurance Program and/or your Copayment or Coinsurance, if any for those eligible Prescription Drug Products, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to Cigna in connection with the Patient Assurance Program. More information about the Patient Assurance Program including the Prescription Drug Products included in the program, is available at the website shown on your ID card or by calling member services at the telephone number on your ID card.		
Certain Preventive Care Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required.		
Generic and Preferred Brand diabetic medications and supplies at No charge		
Prescription Drug Products at Retail Pharmacies	The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy
Tier 1 Generic Drugs on the Prescription Drug List	No charge after \$5 Copay	30%

JA-283



BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after \$10 Copay	30%
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after \$20 Copay	30%
Prescription Drug Products at Home Delivery Pharmacies	The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy
Tier 1 Generic Drugs on the Prescription Drug List	No charge after \$10 Copay	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after \$20 Copay	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after \$40 Copay	In-network coverage only



Prescription Drug Benefits

Covered Expenses

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

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

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

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

Prescription Drug List Management

The Prescription Drug List (or formulary) offered under your Employer's plan is managed by the Cigna Business Decision Team. Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. The Business Decision Team makes the final assignment of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and decides whether utilization management requirements or other coverage conditions should apply to a Prescription Drug Product by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to,

assessments on the cost effectiveness of the Prescription Drug Product and available rebates. When considering a Prescription Drug Product for tier placement on the Prescription Drug List or other coverage conditions, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

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

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Limitations

In the event you or your Dependent insist on a more expensive Brand Drug where a Generic Drug is available, you will be financially responsible for the amount by which the cost of the Brand Drug exceeds the cost of the Generic Drug, plus any required Brand Drug Copayment and/or Coinsurance. In this case, the amount by which the cost of the Brand Drug exceeds the cost of the Generic Drug will not apply to your Deductible, if any, or Out-of-Pocket Maximum. However, in the event your Physician determines that the Generic Drug is not an acceptable alternative for you (and indicates Dispensed as Written on the Prescription Order or Refill), you will only be responsible for payment of the appropriate Brand Drug Coinsurance and/or Copayment after satisfying your Deductible, if any.



Prior Authorization Requirements

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

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

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

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

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

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

Step Therapy

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

Supply Limits

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

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

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

Specialty Prescription Drug Products

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

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you may not receive coverage for the Prescription Drug Product or be subject to the non-Network Pharmacy Benefit, if any, for that Prescription Drug Product. Refer to The Schedule for further information.

New Prescription Drug Products

The Business Decision Team may or may not place a New Prescription Drug Product on Prescription Drug List upon its market entry. The Business Decision Team will use reasonable efforts to make a decision for a New Prescription Drug



Product within six months of its market availability. The Business Decision Team's decision shall be based on consideration of, without limitation, the P&T Committee's clinical review of the New Prescription Drug Product and economic factors. If a New Prescription Drug Product not listed on the Prescription Drug List is approved by Cigna or its Review Organization as Medically Necessary in the interim, the New Prescription Drug Product shall be covered as set forth in The Schedule.

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Your Payments

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

Copayment

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

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

Payments at Non-Network Pharmacies

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

When a treatment regimen contains more than one type of Prescription Drug Products that are packaged together for your

or your Dependent's convenience, any applicable Copayment or Coinsurance may apply to each Prescription Drug Product.

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

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

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Exclusions

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

- coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.
- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products dispensed outside the jurisdiction of the United States, except as required for emergency or Urgent Care treatment.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.



- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).
- Prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- medications used for cosmetic purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth, or medications used to control perspiration and fade cream products.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.
- any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).
- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.

- medications that are experimental investigational or unproven as described under the "General Exclusion and Limitations" section of your plan's certificate.

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Reimbursement/Filing a Claim

Retail Pharmacy

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

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

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

- care for health conditions that are required by state or local law to be treated in a public facility.



- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

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

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and

effective for treating or diagnosing the condition or Sickness for which its use is proposed;

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

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

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- the following services are excluded from coverage regardless of clinical indications: abdominoplasty; panniculectomy; rhinoplasty; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- surgical or non-surgical treatment of TMJ disorders.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Additionally, charges made by a Physician for any of the following Surgical Procedures are covered: excision of unerupted impacted wisdom tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth).
- for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the Body Mass Index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.



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- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
 - court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
 - any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation.
 - medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
 - non-medical counseling and/or ancillary services, including but not limited to Custodial Services, educational services, vocational counseling, training and, rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
 - therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
 - consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
 - private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
 - personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
 - artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
 - aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
 - eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
 - eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
 - all non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
 - routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
 - membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
 - genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
 - dental implants for any condition.
 - fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
 - blood administration for the purpose of general improvement in physical condition.
 - cost of biologicals that are medications for the purpose of travel, or to protect against occupational hazards and risks.
 - cosmetics, dietary supplements and health and beauty aids.
 - for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
 - charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
 - massage therapy.
 - expenses incurred by a participant to the extent reimbursable under automobile insurance coverage. Coverage under this plan is secondary to automobile no-fault insurance or similar coverage. The coverage provided under this plan does not constitute "Qualified Health Coverage" under Michigan law and therefore does not replace Personal Injury Protection (PIP) coverage provided
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under an automobile insurance policy issued to a Michigan resident. This plan will cover expenses only not otherwise covered by the PIP coverage.

General Limitations

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

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.
- charges made for hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs); except as shown in The Schedule and Covered Expenses. A hearing aid is any device that amplifies sound.

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Coordination of Benefits

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

Definitions

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

Plan

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

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

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

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



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

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

Reasonable Cash Value

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

Order of Benefit Determination Rules

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

- The Plan that covers you as an enrollee or an Employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or Employee;

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

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

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

Effect on the Benefits of This Plan

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



Recovery of Excess Benefits

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

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

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Coordination of Benefits with Medicare

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

When Medicare is the Primary Payer

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

- **COBRA or State Continuation**: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to COBRA or state continuation of coverage.
- **Retirement or Termination of Employment**: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to your retirement or termination of employment.
- **Disability**: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active

Employee, and your Employer has fewer than 100 employees.

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

When This Plan is the Primary Payer

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

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

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

Failure to Enroll in Medicare

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



Medicare. Please consult Medicare or the Social Security Administration for more information.

Assistance with Medicare Questions

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

HC-COB200

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Expenses For Which A Third Party May Be Responsible

This plan does not cover:

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

Subrogation/Right of Reimbursement

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

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

Lien of the Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery



rights are neither affected nor diminished by equitable defenses.

- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

HC-SUB77

01-17

Payment of Benefits

Assignment and Payment of Benefits

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

You may, however, authorize Cigna to pay any healthcare benefits under this policy to a Participating or Non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or Non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Expenses directly to a Participating Provider without

your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or Non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

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

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

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

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

Recovery of Overpayment

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

Calculation of Covered Expenses

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

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

HC-POB132

01-19



Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

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

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

Temporary Layoff or Leave of Absence

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

Injury or Sickness

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

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date as defined by your Employer.

Dependents

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

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

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

HC-TRM128 M

12-17

Rescissions

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

HC-TRM80

01-11

Federal Requirements

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

HC-FED1

10-10

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

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

Notice Regarding Pharmacy Directories and Pharmacy Networks

A list of network pharmacies is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of pharmacies affiliated or contracted with Cigna or an organization contracting on its behalf.

HC-FED78

10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as



required by the order and you will not be considered a Late Entrant for Dependent Insurance.

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

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

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

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

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
 - divorce or legal separation;
 - cessation of Dependent status (such as reaching the limiting age);
 - death of the Employee;
 - termination of employment;



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

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will

be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

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

HC-FED96

04-17

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage elections

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

- if you meet Special Enrollment criteria and enroll as described in the Special Enrollment section; or
- if your Employer agrees, and you meet the criteria shown in the following Sections B through H and enroll for or change coverage within the time period established by your Employer.

B. Change of status

A change in status is defined as:

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



C. Court order

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

D. Medicare or Medicaid eligibility/entitlement

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

E. Change in cost of coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

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

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

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

G. Reduction in work hours

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

H. Enrollment in a Qualified Health Plan (QHP)

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

HC-FED95

04-17

Eligibility for Coverage for Adopted Children

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

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

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67

09-14

Coverage for Maternity Hospital Stay

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

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

HC-FED11

10-10



Women's Health and Cancer Rights Act (WHCRA)

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

HC-FED12

10-10

Group Plan Coverage Instead of Medicaid

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

HC-FED13

10-10

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

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

Continuation of Health Insurance During Leave

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

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

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

Reinstatement of Canceled Insurance Following Leave

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

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

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

HC-FED93

10-17

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

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

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

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

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

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

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

Reinstatement of Benefits (applicable to all coverages)

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

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



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

HC-FED18

10-10

Claim Determination Procedures

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

Procedures Regarding Medical Necessity Determinations

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

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

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

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

Preservice Determinations

When you or your representative requests a required prior authorization, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will

be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

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

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

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

Concurrent Determinations

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

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your



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

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

Notice of Adverse Determination

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

HC-FED104

01-19

Appointment of Authorized Representative

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

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

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

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

HC-FED88

01-17

Medical - When You Have a Complaint or an Appeal

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

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

Start With Customer Service

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

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



results of a coverage decision, you may start the appeals procedure.

Internal Appeals Procedure

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

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

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

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

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

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your health care provider would cause you severe pain which cannot be managed without the requested services.

If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

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

External Review Procedure

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

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

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

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

Notice of Benefit Determination on Appeal

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



health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

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

Relevant Information

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

Legal Action

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

HC-FED107

01-20

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your

Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

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

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

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

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

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

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

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event



occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

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

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

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

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

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

Medicare Extension for Your Dependents

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

Termination of COBRA Continuation

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

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

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

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

Employer's Notification Requirements

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

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
 - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the



Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;

- if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
- in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

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

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

How Much Does COBRA Continuation Coverage Cost?

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

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

Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

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

You Must Give Notice of Certain Qualifying Events

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

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice



must be received prior to the end of the initial 18- or 29-month COBRA period).

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

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

Newly Acquired Dependents

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

COBRA Continuation for Retirees Following Employer’s Bankruptcy

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

Interaction With Other Continuation Benefits

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

HC-FED66

07-14

Definitions

Active Service

You will be considered in Active Service:

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

HC-DFS1095 M

12-17

Bed and Board

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

HC-DFS2

04-10

V2

Biologic

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

HC-DFS840

10-16

Biosimilar

A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009,



title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS841

10-16

Brand Drug

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

HC-DFS842

10-16

Business Decision Team

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

HC-DFS843

10-16

Charges

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

HC-DFS1193

01-19

Cigna Home Delivery Pharmacy

A home delivery Network Pharmacy owned and operated by licensed Pharmacy affiliates of Cigna Health and Life Insurance Company.

HC-DFS844

10-16

Custodial Services

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

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

HC-DFS4

04-10

V1

Dependent

Dependents are:

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

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



The term child means a child born to you or a child legally adopted by you. It also includes a stepchild or a child for whom you are the legal guardian.

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

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

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

Federal rights may not be available to Civil Union partners or Dependents

Connecticut law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons of the opposite sex under federal law may not be available to parties to a civil union.

HC-DFS872 M

10-16

Designated Pharmacy

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

HC-DFS845

10-16

Emergency Medical Condition

Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or

her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

HC-DFS394

11-10

Emergency Services

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

HC-DFS393

11-10

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than the number of hours as determined by collective bargaining.

HC-DFS1094 M

12-17

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf Cigna is providing claim administration services.

HC-DFS8

04-10

VI



Essential Health Benefits

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

HC-DFS411

01-11

Expense Incurred

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

HC-DFS10

04-10

V1

Free-Standing Surgical Facility

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

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

HC-DFS11

04-10

V1

Generic Drug

A Prescription Drug Product that Cigna identifies as a Generic Drug product at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator

source, that classify drugs or Biologics (including Biosimilars) as either brand or generic based on a number of factors. Not all products identified as a “generic” by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the plan. A Biosimilar may be classified as a Generic Drug for the purposes of benefits under the plan even if it is identified as a “brand name” drug by the manufacturer, Pharmacy or your Physician.

HC-DFS846

10-16

Hospice Care Program

The term Hospice Care Program means:

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

HC-DFS51

04-10

V1

Hospice Care Services

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

HC-DFS52

04-10

V1

Hospice Facility

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

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

HC-DFS53

04-10

V1



Hospital

The term Hospital means:

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

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

HC-DFS806

12-15

Hospital Confinement or Confined in a Hospital

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

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

HC-DFS807

12-15

Injury

The term Injury means an accidental bodily injury.

HC-DFS12

04-10

V1

Maximum Reimbursable Charge - Medical

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

- the provider's normal charge for a similar service or supply; or

- a policyholder-selected percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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

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

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

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

HC-DFS1365

06-19

Medicaid

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

HC-DFS16

04-10

V1



Medical Pharmaceutical

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

HC-DFS848

10-16

Medically Necessary/Medical Necessity

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

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

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

reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

HC-DFS1195

01-19

Medicare

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

HC-DFS17

04-10

V1

Necessary Services and Supplies

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

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

HC-DFS21

04-10

V1

Network Pharmacy

A retail or home delivery Pharmacy that has:

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

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

HC-DFS1198

01-19



New Prescription Drug Product

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

HC-DFS850

10-16

Nurse

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

HC-DFS22

04-10
V1

Other Health Care Facility/Other Health Professional

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

HC-DFS23

04-10
V1

Participating Provider

The term Participating Provider means a person or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies, the Charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the

provision of any services and/or supplies, the Charges for which are Covered Expenses.

HC-DFS1194

01-19

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

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

HC-DFS412

01-11

Pharmacy

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

HC-DFS851

10-16

Pharmacy & Therapeutics (P&T) Committee

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

HC-DFS852

10-16

Physician

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

- operating within the scope of his license; and



- performing a service for which benefits are provided under this plan when performed by a Physician.

HC-DFS25

04-10
V1

Prescription Drug Charge

The Prescription Drug Charge is the amount that, prior to application of the plan's cost-share requirement(s), the plan sponsor is obligated to pay for a covered Prescription Drug Product dispensed at a Network Pharmacy, including any applicable dispensing fee and tax.

HC-DFS1320

01-19
V1

Prescription Drug List

A list that categorizes drugs, Biologics (including Biosimilars) or other products covered under the plan's Prescription Drug Benefits that have been approved by the U.S. Food and Drug Administration (FDA) into coverage tiers. This list is developed by Cigna's Business Decision Team based on clinical factors communicated by the P&T Committee, and adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.

HC-DFS854

10-16

Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the plan, this definition also includes:

- The following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (but excluding insulin pumps), needles

including pen needles, syringes, test strips, lancets, urine glucose and ketone strips;

- Needles and syringes for self-administered medications or Biologics covered under the plan's Prescription Drug benefit; and
- Inhaler assistance devices and accessories, peak flow meters.

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

HC-DFS855

10-16

Prescription Order or Refill

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

HC-DFS856

10-16

Preventive Care Medications

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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

HC-DFS857

10-16



Primary Care Physician

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

HC-DFS40

04-10
V1

Psychologist

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

HC-DFS26

04-10
V1

Review Organization

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

HC-DFS808

12-15

Sickness – For Medical Insurance

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

HC-DFS50

04-10
V1

Skilled Nursing Facility

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

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

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

HC-DFS31

04-10
V1

Specialist

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

HC-DFS33

04-10
V1



Specialty Prescription Drug Product

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

HC-DFS858

10-16

Stabilize

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

HC-DFS413

01-11

Terminal Illness

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

HC-DFS54

04-10

V1

Therapeutic Alternative

A Prescription Drug Product or Medical Pharmaceutical that is of the same therapeutic or pharmacological class, and usually

can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

HC-DFS859

10-16

Therapeutic Equivalent

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

HC-DFS860

10-16

Urgent Care

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

HC-DFS34

04-10

V1

Usual and Customary (U&C) Charge

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

HC-DFS861

10-16

JA-316

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Exhibit B

JA-317

Case 3:25-cv-00498-SRU
 Cigna Health and Life Insurance Company
 SCRANTON CLAIM OFFICE
 P.O. BOX 182223
 CHATTANOOGA TN 37422-7223

Document 36-4

Filed 01/12/26

Page 2 of 4

000049

Cigna Health and Life Insurance Company
 AS AGENT FOR:



Provider Number:

474541206 0016

Date through which claims were processed:

OCTOBER 25, 2023

Remittance Tracking Number:

How to Contact Us

★ Mail to the return address in upper
 left corner of this page

➔ <http://www.cigna.com>

↑ Phone:

RICHARD L AGAG MD
 456 WASHINGTON ST APT 8E
 NEW YORK NY 10013-1554

Provider Explanation of Medical Benefits

Understanding this Benefits Statement

- ☞ This page provides a summary of the payments made this period.
- ☞ The accompanying pages give more detail on the claims we processed for this period.
 Please review both the front and back of each page to see how the benefit amounts shown in the Explanation of Medical Benefits Report were determined.

In the event a claim is denied.....

Rights of Review and Appeal - For Physician or Health Care Provider

- ☞ If you have questions or disagree with the payment identified on this Explanation of Medical Benefits statement, you may ask to have it reviewed.
- ☞ If you have a contractual agreement with Cigna HealthCare, please refer to the procedural guidelines associated with your Cigna HealthCare contract, or call our office for assistance.

Federal Rights of Review and Appeal - For Employee

Call Member Services at the toll free number on this Explanation of Benefits (EOB) or your ID card if you have questions regarding this EOB.

If you're not satisfied with this coverage decision, you can start the Appeal process by submitting a written request to the address listed in your plan materials within 180 days of receipt of this EOB (unless a longer time is permitted by state law or your plan). Send a copy of this EOB along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. Contact Member Services if you need further instructions on how and where to send your request for review.

Be sure to include your 1) Name, 2) Operation Location/Group Number, 3) Employee/Patient ID number, 4) Name of the patient and relationship, and 5) "Attention: Appeals Unit" on all supporting documents.

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

You will be notified of the final decision in a timely manner, as described in your plan materials. If your plan is governed by ERISA, you also have the right to bring legal action under section 502(a) of ERISA following our review.

Provider Summary

No Payment was made with this statement

The charges submitted were negated or offset by the deductibles, coinsurance, etc., or the patient(s) may be incurring liability for payment. See the following provider detail page for an explanation of how the benefits were determined.

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Definitions of terms used on the Provider Explanation of Medical Benefits Report section of this statement

Line:	Line item number.
Procedure Date:	Date you provided the service.
Procedure Code:	Code describing the service provided.
Adjusted Procedure Code:	Re-assigned procedure code (See Note).
Billed Amount:	Dollar amount you charged for service.
Adjusted Procedure Code Amount:	Dollar amount due to adjusted procedure code.
Allowed Amount:	Dollar amount covered by benefit plan.
Not Covered / Discount:	Part of "Billed Amount" Not Covered under the benefit plan or a Provider Discount.
Deduct / Copay Amount:	Portion of billed amount applied toward patient's deductible or copay (if any).
Coinsurance Amount:	The amount of the patient's coinsurance liability.
DRG / Per Diem / APC Type:	DRG (Diagnosis Related Group) / Per Diem / APC (Ambulatory Payment Classification) Category.
DRG / Per Diem / APC Number:	DRG (Diagnosis Related Group) /Per Diem / APC (Ambulatory Payment Classification) Code describing the service provided.
DRG / Per Diem Amount:	Dollar amount for DRG (Diagnosis Related Group) / Per Diem service provided.
DRG / Per Diem Benefit Amount:	Dollar amount payable by the benefit plan for DRG (Diagnosis Related Group) /Per Diem services.
Plan Benefit:	Dollar amount payable for services provided.
See Note:	If a portion or all of the charge is Not Covered, this is the written explanation of why it is Not Covered.
Other Insurance Paid:	The amount of another insurance carrier's payment.

JA-319



Provider Explanation of Medical Benefits Report

Provider Number 474541206 0016		Provider Name RICHARD L AGAG MD		Date through which claims were processed 10/25/2023						THIS IS NOT A BILL Retain for Your Records				Page 1	
Line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Not Covered/Discount	Deduct/Copay Amount	Coinsurance Amount	DRG / Per Diem / APC Type	DRG / Per Diem / APC Number	DRG/Per Diem Amount	Per Diem Benefit Amount	Plan Benefit	See Note
Reminder: A coverage determination, prior authorization, or certification that is made prior to a service being performed is not a promise to pay for the service at any particular rate or amount. The patient's summary plan description governs amount payable, as every claim submitted is subject to all plan provisions, including, but not limited to, eligibility requirements, exclusions, limitations, and applicable state mandates.															
PATIENT NAME: M L PATIENT#: OPERATION LOCATION/GROUP# 38724-9-3329502 RECEIVE DATE: 10/09/2023 PROCESS DATE: 10/25															
PATIENT'S RELATIONSHIP TO SUBSCRIBER: DEPENDENT PROVIDER NETWORK STATUS: OUT OF NETWORK REF#: 4682328298918															
SUBSCRIBER NAME: SUBSCRIBER#: 1960000.00															
1	04142023	4142023	19364	196000.00			1960000.00					0.00	0.00	0.00	A0
2	04142023	4142023	38530	10900.00			10900.00					0.00	0.00	0.00	A0
3	04142023	4142023	11971	24000.00			24000.00					0.00	0.00	0.00	A1
TOTAL				230900.00			2309000.00							0.00	
BALANCE..... \$206,900.00															
** NOTES ON BENEFIT DETERMINATION:															
IF YOU HAVE ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE REFERENCE NUMBER ON INQUIRIES.															
DHC-AAY															
VIEW ELIGIBILITY, BENEFITS, AND CLAIM DETAILS AND GET PRECERTIFICATION ANSWERS FAST AT THE CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE (WWW.CIGNA4ORHCP.COM)															
A0) BASED ON THE INFORMATION WE HAVE AVAILABLE, THE SERVICES OR SUPPLIES ON THIS CLAIM ARE NOT MEDICALLY NECESSARY.															
A1) THIS PROCEDURE DOES NOT GENERALLY REQUIRE THE ASSISTANCE OF A CO-SURGEON. YOUR CIGNA CONTRACT DOESN'T ALLOW YOU TO BILL THE PATIENT FOR THE CHARGES															

G2433C 04-08-2015

PROCLAIM Provider Checkless EOP Summary



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Exhibit C

JA-321

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Unilever United States Inc

OPEN ACCESS PLUS MEDICAL
BENEFITS
Choice Plan

EFFECTIVE DATE: January 1, 2018

ASO1
2500523

This document printed in February, 2018 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

JA-322

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Important Information

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

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

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Explanation of Terms

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

The Schedule

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



Special Plan Provisions

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

Services Available in Conjunction With Your Medical Plan

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

HC-SPP44

04-17

Case Management

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

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

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

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

HC-SPP2

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Additional Programs

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



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

HC-SPP3

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Care Management and Care Coordination Services

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

HC-SPP27

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Important Notices

Direct Access to Obstetricians and Gynecologists

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

Selection of a Primary Care Provider

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

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

HC-NOT5

01-11

Important Information

Rebates and Other Payments

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

Coupons, Incentives and Other Communications

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

HC-IMP188

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Discrimination is Against the Law

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

Cigna:

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



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

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

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

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

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

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

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

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Proficiency of Language Assistance Services

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

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

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

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. dành cho khách hàng hiện tại của

Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

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

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

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

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

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

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

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

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

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



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

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

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

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

HC-NOT97

07-17

How To File Your Claim

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

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

CLAIM REMINDERS

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

Timely Filing of Out-of-Network Claims

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

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

HC-CLM25

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Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 20 hours a week; and
- you pay any required contribution.

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

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

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



Eligibility for Dependent Insurance

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

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

Waiting Period

Initial Employee Group: None.

New Employee Group: None.

Classes of Eligible Employees

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

Effective Date of Employee Insurance

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

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

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 31 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

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

Effective Date of Dependent Insurance

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

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 31 days after you become eligible for it; or

- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns

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

HC-ELG154

04-17

Important Information About Your Medical Plan

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

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

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

Changing Primary Care Physicians:

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

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

HC-IMP212

01-18



Open Access Plus Medical Benefits The Schedule	
For You and Your Dependents	
Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance. When you receive services from an In-Network Provider, remind your provider to utilize In-Network Providers for x-rays, lab tests and other services to ensure the cost may be considered at the In-Network level. If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.	
Coinsurance	
The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.	
Copayments/Deductibles	
Copayments are expenses to be paid by you or your Dependent for covered services. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.	
Out-of-Pocket Expenses - For In-Network Charges Only	
Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.	
Out-of-Pocket Expenses - For Out-of-Network Charges Only	
Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%: • Coinsurance. • Plan Deductible. The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached: • Non-compliance penalties. • Any copayments and/or benefit deductibles. • Provider charges in excess of the Maximum Reimbursable Charge.	
Accumulation of Plan Deductibles and Out-of-Pocket Maximums	
Deductibles and Out-of-Pocket Maximums will cross-accumulate (that is, In-Network will accumulate to Out-of-Network and Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) also cross-accumulate between In- and Out-of-Network unless otherwise noted.	

JA-333



Open Access Plus Medical Benefits

The Schedule

Multiple Surgical Reduction

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

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

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

Co-Surgeon

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

Out-of-Network Emergency Services Charges

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

The member is responsible for the applicable In-Network cost-sharing amounts. The member also is responsible for all charges in excess of the allowable amount unless a negotiated amount is agreed to by the Out-of-Network provider and Cigna.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
The Percentage of Covered Expenses the Plan Pays	85%	65% of the Maximum Reimbursable Charge



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maximum Reimbursable Charge Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected. Note: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance. Note: Some providers forgive or waive the cost share obligation (e.g. your copayment, deductible and/or coinsurance) that this plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this plan. For more details, see the Exclusions Section.	Not Applicable	90th Percentile
Calendar Year Deductible Individual Individual Plus One Family Maximum Individual Calculation: Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.	\$400 per person \$800 per person Plus One \$1,000 per family	\$800 per person \$1,600 per person Plus One \$2,000 per family

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Out-of-Pocket Maximum Individual Individual Plus One Family Maximum Individual Calculation: Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.	\$2,500 per person \$5,000 per person Plus One \$6,250 per family	\$5,000 per person \$10,000 per person Plus One \$12,500 per family

JA-336



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office Visit	\$25 per visit copay, then 100%	Plan deductible, then 65%
Specialty Care Physician's Office Visits	\$35 per visit copay, then 100%	Plan deductible, then 65%
Consultant and Referral Physician's Services		
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna on an In-Network basis. Out-of-Network OB/GYN providers will be considered a Specialist.		
Surgery Performed in the Physician's Office		
Primary Care Physician	\$25 per visit copay, then 100%	Plan deductible, then 65%
Specialty Care Physician	\$35 per visit copay, then 100%	Plan deductible, then 65%
Second Opinion Consultations (provided on a voluntary basis)		
Primary Care Physician's Office Visit	\$25 per visit copay, then 100%	Plan deductible, then 65%
Specialty Care Physician's Office Visit	\$35 per visit copay, then 100%	Plan deductible, then 65%
Allergy Treatment/Injections		
Primary Care Physician's Office Visit	\$25 per visit copay, then 100%	Plan deductible, then 65%
Specialty Care Physician's Office Visit	\$35 per visit copay, then 100%	Plan deductible, then 65%
Allergy Serum (dispensed by the Physician in the office)		
Primary Care Physician	100%	Plan deductible, then 65%
Specialty Care Physician	100%	Plan deductible, then 65%
Medical Telehealth		
Primary Care Physician	\$25 per visit copay, then 100%	In-Network coverage only
Specialty Care Physician	\$25 per visit copay, then 100%	In-Network coverage only

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Preventive Care Note: Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit. Routine Preventive Care - all ages Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Immunizations - all ages Primary Care Physician's Office Visit Specialty Care Physician's Office Visit	100% 100% 100% 100%	Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65%
Mammograms, PSA, PAP Smear Preventive Care Related Services (i.e. "routine" services) Diagnostic Related Services (i.e. "non-routine" services)	100% Subject to the plan's x-ray benefit & lab benefit; based on place of service	Subject to the plan's x-ray benefit & lab benefit; based on place of service Subject to the plan's x-ray benefit & lab benefit; based on place of service
Inpatient Hospital - Facility Services Semi-Private Room and Board Private Room Special Care Units (ICU/CCU)	Plan deductible, then 85% Limited to the semi-private room negotiated rate Limited to the semi-private room negotiated rate Limited to the negotiated rate	Plan deductible, then 65% Limited to the semi-private room rate Limited to the semi-private room rate Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	Plan deductible, then 85%	Plan deductible, then 65%
Inpatient Hospital Physician's Visits/Consultations	Plan deductible, then 85%	Plan deductible, then 65%
Inpatient Professional Services Surgeon Radiologist, Pathologist, Anesthesiologist	Plan deductible, then 85%	Plan deductible, then 65%

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Professional Services Surgeon Radiologist, Pathologist, Anesthesiologist	Plan deductible, then 85%	Plan deductible, then 65%
Urgent Care Services Urgent Care Facility or Outpatient Facility Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the UC visit. Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the UC visit	\$50 per visit copay, then 85% \$50 per visit copay, then 85%	\$50 per visit copay, then 85% \$50 per visit copay, then 85%
Emergency Services Hospital Emergency Room Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER visit	\$100 per visit copay (waived if admitted), then 100% \$100 per visit copay (waived if admitted), then 100%	\$100 per visit copay (waived if admitted), then 100% \$100 per visit copay (waived if admitted), then 100%
Ambulance	Plan deductible, then 85%	Plan deductible, then 85%
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 120 days combined	Plan deductible, then 85%	Plan deductible, then 65%

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Laboratory Services		
Primary Care Physician's Office Visit	\$25 per visit copay, then 100%	Plan deductible, then 65%
Specialty Care Physician's Office Visit	\$35 per visit copay, then 100%	Plan deductible, then 65%
Outpatient Hospital Facility	Plan deductible, then 85%	Plan deductible, then 65%
Independent Lab Facility	Plan deductible, then 85%	Plan deductible, then 65%
Radiology Services		
Primary Care Physician's Office Visit	\$25 per visit copay, then 100%	Plan deductible, then 65%
Specialty Care Physician's Office Visit	\$35 per visit copay, then 100%	Plan deductible, then 65%
Outpatient Hospital Facility	Plan deductible, then 85%	Plan deductible, then 65%

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans) Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Inpatient Facility Outpatient Facility	\$25 per visit copay, then 100% \$35 per visit copay, then 100% Plan deductible, then 85% Plan deductible, then 85%	Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65%
Outpatient Short-Term Rehabilitative Therapy and Chiropractic Services Calendar Year Maximum: 60 days for all therapies combined (The limit is not applicable to mental health conditions.) Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Chiropractic Therapy (includes Chiropractors) Primary Care Physician's Office Visit Specialty Care Physician's Office Visit	\$25 per visit copay*, then 100% \$35 per visit copay*, then 100% *Note: Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.	Plan deductible, then 65% Plan deductible, then 65%
Home Health Care Calendar Year Maximum: 120 days (includes outpatient private nursing when approved as Medically Necessary) (The limit is not applicable to Mental Health and Substance Use Disorder conditions.)	\$35 per visit copay, then 100%	Plan deductible, then 65%

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Hospice Inpatient Services Outpatient Services (same coinsurance level as Home Health Care)	100% 100%	Plan deductible, then 65% Plan deductible, then 65%
Bereavement Counseling Services provided as part of Hospice Care Inpatient Outpatient Services provided by Mental Health Professional	100% 100% Covered under Mental Health Benefit	Plan deductible, then 65% Plan deductible, then 65% Covered under Mental Health Benefit
Medical Pharmaceuticals Physician's Office Home Care Inpatient Facility Outpatient Facility	Plan deductible, then 85% Plan deductible, then 85% Plan deductible, then 85% Plan deductible, then 85%	Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65%

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Women's Family Planning Services Office Visits, Lab and Radiology Tests and Counseling Note: Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.		
Primary Care Physician	100%	In-Network coverage only
Specialty Care Physician	100%	In-Network coverage only
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)		
Primary Care Physician's Office Visit	100%	In-Network coverage only
Specialty Care Physician's Office Visit	100%	In-Network coverage only
Inpatient Facility	100%	In-Network coverage only
Outpatient Facility	100%	In-Network coverage only
Inpatient Professional Services	100%	In-Network coverage only
Outpatient Professional Services	100%	In-Network coverage only
Men's Family Planning Services Office Visits, Lab and Radiology Tests and Counseling Primary Care Physician Specialty Care Physician Surgical Sterilization Procedures for Vasectomy (excludes reversals) Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Inpatient Facility Outpatient Facility Inpatient Professional Services Outpatient Professional Services	\$25 per visit copay, then 100% \$35 per visit copay, then 100% \$25 per visit copay, then 100% \$35 per visit copay, then 100% Plan deductible, then 85% Plan deductible, then 85% Plan deductible, then 85% Plan deductible, then 85%	Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65%

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination, In-vitro, GIFT, ZIFT, etc.		
Physician's Office Visit (Lab and Radiology Tests, Counseling) Primary Care Physician Specialty Care Physician Inpatient Facility Outpatient Facility Inpatient Professional Services Outpatient Professional Services Lifetime Maximum: \$10,000 per member Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility). Note: All infertility medications have a combined lifetime maximum of \$20,000.	\$25 per visit copay, then 100% \$35 per visit copay, then 100% Plan deductible, then 85% Plan deductible, then 85% Plan deductible, then 85% Plan deductible, then 85%	Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65%
Organ Transplants Includes all medically appropriate, non-experimental transplants Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Inpatient Facility Inpatient Professional Services Lifetime Travel Maximum: \$10,000 per transplant	\$25 per visit copay, then 100% \$35 per visit copay, then 100% 100% at Lifesource center, otherwise plan deductible, then 85% 100% at Lifesource center, otherwise, plan deductible, then 85% 100% (only available when using Lifesource facility)	In-Network coverage only In-Network coverage only In-Network coverage only In-Network coverage only In-Network coverage only

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment Calendar Year Maximum: Unlimited	Plan deductible, then 85%	Plan deductible, then 65%
Hearing Aids Maximum: 2 devices every 5 years	Plan deductible, then 85%	Plan deductible, then 65%
Wigs Lifetime Maximum: 2 wigs	Plan deductible, then 85%	Plan deductible, then 85%
Breast Feeding Equipment and Supplies Note: Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	100%	In-Network coverage only
External Prosthetic Appliances Calendar Year Maximum: Unlimited	Plan deductible, then 85%	Plan deductible, then 65%
Nutritional Evaluation Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of mental health and substance use disorder conditions. Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Inpatient Facility Outpatient Facility Inpatient Professional Services Outpatient Professional Services	 \$25 per visit copay, then 100% \$35 per visit copay, then 100% Plan deductible, then 85% Plan deductible, then 85% Plan deductible, then 85% Plan deductible, then 85%	 Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65%

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to teeth. Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Inpatient Facility Outpatient Facility Inpatient Professional Services Outpatient Professional Services	\$25 per visit copay, then 100% \$35 per visit copay, then 100% Plan deductible, then 85% Plan deductible, then 85% Plan deductible, then 85% Plan deductible, then 85%	Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65%
TMJ Surgical and Non-Surgical Always excludes appliances and orthodontic treatment. Subject to medical necessity. Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Inpatient Facility Outpatient Facility Inpatient Professional Services Outpatient Professional Services	\$25 per visit copay, then 100% \$35 per visit copay, then 100% Plan deductible, then 85% Plan deductible, then 85% Plan deductible, then 85% Plan deductible, then 85%	Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65%

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Obesity/Bariatric Surgery Note: Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the “Exclusions, Expenses Not Covered and General Limitations” section of this certificate. Primary Care Physician’s Office Visit Specialty Care Physician’s Office Visit Inpatient Facility Outpatient Facility Inpatient Professional Services Outpatient Professional Services Surgical Professional Services Lifetime Maximum: \$25,000 Notes: Includes charges for surgeon only; does not include radiologist, anesthesiologist, etc.	\$25 per visit copay, then 100% \$35 per visit copay, then 100% Plan deductible, then 85% Plan deductible, then 85% Plan deductible, then 85% Plan deductible, then 85%	In-Network coverage only In-Network coverage only In-Network coverage only In-Network coverage only In-Network coverage only In-Network coverage only
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health Inpatient Includes Acute Inpatient and Residential Treatment Calendar Year Maximum: Unlimited Outpatient Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, Behavioral Telehealth consultation, etc. Calendar Year Maximum: Unlimited Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, Behavioral Telehealth consultation, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 85% \$25 per visit copay, then 100% Plan deductible, then 85%	Plan deductible, then 65% Plan deductible, then 65% Plan deductible, then 65%

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Substance Use Disorder		
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Calendar Year Maximum: Unlimited	Plan deductible, then 85%	Plan deductible, then 65%
Outpatient Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, Behavioral Telehealth consultation, etc. Calendar Year Maximum: Unlimited	\$25 per visit copay, then 100%	Plan deductible, then 65%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, Behavioral Telehealth consultation, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 85%	Plan deductible, then 65%



Open Access Plus Medical Benefits

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

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

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

Covered Expenses incurred will not include the first \$750 of Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission.

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

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

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

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

Outpatient Certification Requirements – Out-of-Network

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

Covered Expenses incurred will not include the first \$750 for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

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

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

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Hysterectomy.

HC-PAC44

12-15

Prior Authorization/Pre-Authorized

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

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

- inpatient Hospital services, except for 48/96 hour maternity stays;



- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- outpatient facility services;
- Partial Hospitalization;
- advanced radiological imaging;
- non-emergency ambulance;
- certain Medical Pharmaceuticals; or
- transplant services.

HC-PRA26

10-16

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.

- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges made for the following preventive care services (detailed information is available at www.healthcare.gov):
 - (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
 - (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
 - (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
 - (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- charges made for surgical or nonsurgical treatment of Temporomandibular Joint Dysfunction.
- charges made for hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- includes charges for the delivery of medical and health-related consultations via secure telecommunications



technologies, including telephones and internet, when delivered through a contracted medical telehealth provider.

Covered Expenses – Mental Health and Substance Use Disorder

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

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

If your plan includes In-Network providers, Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

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

Genetic Testing

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

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

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

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing. The visit limit does not apply to genetic counseling related to treatment of mental health and/or substance use disorders.



Nutritional Evaluation

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

Internal Prosthetic/Medical Appliances

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

HC-COV604

08-17

Obesity Treatment

- charges made for medical and surgical services only at approved centers for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer reviewed, evidence based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities. The following items are specifically excluded:
 - medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity; and
 - weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

HC-COV2

04-10
V1

Orthognathic Surgery

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

- the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

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

HC-COV3

04-10
V1

Home Health Services

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

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

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

HC-COV5

04-10
V1



Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
 - by a Hospice Facility for Bed and Board and Services and Supplies;
 - by a Hospice Facility for services provided on an outpatient basis;
 - by a Physician for professional services;
 - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
 - for pain relief treatment, including drugs, medicines and medical supplies;
 - by an Other Health Care Facility for:
 - part-time or intermittent nursing care by or under the supervision of a Nurse;
 - part-time or intermittent services of an Other Health Care Professional;
 - physical, occupational and speech therapy;
 - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

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

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

HC-COV6

04-10
V1

Mental Health and Substance Use Disorder Services

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

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

Inpatient Mental Health Services

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

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

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

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

Outpatient Mental Health Services

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



intervention and relapse prevention) and outpatient testing and assessment.

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

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

Inpatient Substance Use Disorder Rehabilitation Services

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

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

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

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

Outpatient Substance Use Disorder Rehabilitation Services

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

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

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

Substance Use Disorder Detoxification Services

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

Exclusions

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

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

HC-COV481

12-15

Durable Medical Equipment

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



person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

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

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

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

HC-COV8

04-10
v2

External Prosthetic Appliances and Devices

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

congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

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

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts.

Prostheses/prosthetic appliances and devices include, but are not limited to:

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

Orthoses and Orthotic Devices

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

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

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for



synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;

- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

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

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
 - no more than once every 24 months for persons 19 years of age and older;
 - no more than once every 12 months for persons 18 years of age and under; and
 - replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

HC-COV9

04-10
V2

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has

been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and the services of an embryologist.

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are specifically excluded infertility services:

- reversal of male and female voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges and services;
- cryopreservation of donor sperm and eggs; and
- any experimental, investigational or unproven infertility procedures or therapies.

HC-COV11

04-10
V2

Short-Term Rehabilitative Therapy and Chiropractic Care Services

- charges made for Short-term Rehabilitative Therapy that is part of a rehabilitative program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Also included are services that are provided by a chiropractic Physician when provided in an outpatient setting. Services of a chiropractic Physician include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

The following limitation applies to Short-term Rehabilitative Therapy and Chiropractic Care Services:

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



Short-term Rehabilitative Therapy and Chiropractic Care services that are not covered include but are not limited to:

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrences or to maintain the patient's current status;

The following are specifically excluded from Chiropractic Care Services:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- vitamin therapy.

If multiple outpatient services are provided on the same day they constitute one day.

A separate Copayment will apply to the services provided by each provider.

HC-COV12

04-10
V1

Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a

result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

HC-COV14

04-10
V1

Transplant Services

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

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

All Transplant services, other than cornea, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at 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 In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are not covered.

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

Transplant Travel Services

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



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

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

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

HC-COV482

12-15

Medical Pharmaceuticals

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

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

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to

step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug Product first.

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

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

HC-COV526

10-16

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.



- treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received. Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or

devices that are determined by the utilization review Physician to be:

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

In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.



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- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
 - court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
 - any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation.
 - medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
 - non-medical counseling and/or ancillary services, including but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
 - therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
 - consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
 - private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
 - personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
 - artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
 - aids or devices that assist with non-verbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
 - eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
 - routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
 - treatment by acupuncture.
 - all non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
 - routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
 - membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
 - genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
 - dental implants for any condition.
 - fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
 - blood administration for the purpose of general improvement in physical condition.
 - cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
 - cosmetics, dietary supplements and health and beauty aids.
 - all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
 - medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a non-Participating Provider.
 - medical treatment when payment is denied by a Primary Plan because treatment was received from a non-Participating Provider.
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- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, email, internet consultations, and telemedicine.
- charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
- massage therapy.

General Limitations

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

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your or your Dependent's family.
- expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.

HC-EXC273 M

10-16

Coordination of Benefits

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

Definitions

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

Plan

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

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

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

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



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

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

Reasonable Cash Value

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

Order of Benefit Determination Rules

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

- The Plan that covers you as an enrollee or an Employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or Employee;

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

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

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

Effect on the Benefits of This Plan

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



Recovery of Excess Benefits

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

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

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles

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

- (a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;
- (d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;
- (e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;
- (f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare

due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

Cigna will assume the amount payable under:

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

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

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

Domestic Partners

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

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Expenses For Which A Third Party May Be Responsible

This plan does not cover:

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



under this plan is secondary to any automobile no-fault or similar coverage.

Subrogation/Right of Reimbursement

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

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

Lien of the Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.

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

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Payment of Benefits

Assignment and Payment of Benefits

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

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

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

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

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

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

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from

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

Calculation of Covered Expenses

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

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

HC-POB89

01-17

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

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

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

Temporary Layoff or Leave of Absence

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



Injury or Sickness

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

Dependents

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

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

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

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Rescissions

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

HC-TRM80

01-11

Federal Requirements

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

HC-FED1

10-10

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

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

HC-FED78

10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

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

Qualified Medical Child Support Order Defined

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

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



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

Payment of Benefits

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

HC-FED4

10-10

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

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

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

in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.

- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
 - divorce or legal separation;
 - cessation of Dependent status (such as reaching the limiting age);
 - death of the Employee;
 - termination of employment;
 - reduction in work hours to below the minimum required for eligibility;
 - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
 - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
 - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of Employer contributions (excluding continuation coverage).** If a current or former Employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the Employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage



available to the individual. This does not include termination of an Employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 31 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

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

HC-FED90

04-17

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 31 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through H.

B. Change of Status

A change in status is defined as:

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

C. Court Order

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

D. Medicare or Medicaid Eligibility/Entitlement

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

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

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

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

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



G. Reduction in work hours

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

H. Enrollment in Qualified Health Plan (QHP)

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

HC-FED91

04-17

Eligibility for Coverage for Adopted Children

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

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

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67

09-14

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the "Newborns' and Mothers' Health Protection Act": restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider

obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

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

HC-FED11

10-10

Women's Health and Cancer Rights Act (WHCRA)

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

HC-FED12

10-10

Group Plan Coverage Instead of Medicaid

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

HC-FED13

10-10

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

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

Continuation of Health Insurance During Leave

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

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and



• you are an eligible Employee under the terms of that Act.
The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

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

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

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

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.

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HC-FED93

10-17

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

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

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

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

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

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

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

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your

Claim Determination Procedures under ERISA

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

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.

Medical Necessity determinations are made on a preservice, concurrent, or postservice basis, as described below:

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

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

Preservice Determinations

When you or your representative requests a required prior authorization, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more



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

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

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

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

Concurrent Determinations

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

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after

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

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

Notice of Adverse Determination

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

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Appointment of Authorized Representative

You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However,



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

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

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

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

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Medical - When You Have a Complaint or an Appeal

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

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

Start With Customer Service

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

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

Internal Appeals Procedure

To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write us at the toll-free number on your ID card, explanation of benefits, or claim form.

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

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

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

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

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

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

External Review Procedure

If you are not fully satisfied with the decision of Cigna's internal appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are



not employed by Cigna, or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant's rights to any other benefits under the plan.

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

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

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

Notice of Benefit Determination on Appeal

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

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

Relevant Information

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

Legal Action

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

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COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

- your termination of employment for any reason, other than gross misconduct; or



- your reduction in work hours.

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

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

Who is Entitled to COBRA Continuation?

Only a “qualified beneficiary” (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

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

Secondary Qualifying Events

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

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or

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

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

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

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

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

Medicare Extension for Your Dependents

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

Termination of COBRA Continuation

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

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



maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;

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

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

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

Employer's Notification Requirements

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

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

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation

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

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

How Much Does COBRA Continuation Coverage Cost?

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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

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



you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

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

You Must Give Notice of Certain Qualifying Events

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

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

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

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

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may

continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer’s Bankruptcy

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

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.

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ERISA Required Information

The name of the Plan is:

UNICare Health Care Plan

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

Unilever United States, Inc
700 Sylvan Avenue
Englewood Cliffs, NJ 07632
201-894-4000

Employer Identification
Number (EIN):

132915928

Plan Number:

550

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

Employer named above



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

Employer named above

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

The Cigna Claim Office responsible for this Plan

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

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

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

Plan Trustees

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

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

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

Discretionary Authority

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

Plan Modification, Amendment and Termination

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

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

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

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

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

Statement of Rights

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

Receive Information About Your Plan and Benefits

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



Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HC-FED72

05-15

Definitions

Active Service

You will be considered in Active Service:

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

HC-DFS1

04-10

V1

Bed and Board

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

HC-DFS2

04-10

V2

Biologic

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L.



No. 111-148, § 7002 (2010), and as may be amended thereafter).

HC-DFS840

10-16

Biosimilar

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

HC-DFS841

10-16

Business Decision Team

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

HC-DFS843

10-16

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount.

HC-DFS3

04-10
V1

Custodial Services

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

they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

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

HC-DFS4

04-10
V1

Dependent

Dependents are:

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

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

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild, a foster child, or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

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

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



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

HC-DFS872

10-16

Domestic Partner

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

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

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

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

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

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

HC-DFS47

04-10

V1

Emergency Medical Condition

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

HC-DFS394

11-10

Emergency Services

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

HC-DFS393

11-10

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 20 hours a week for the Employer.

HC-DFS7

04-10

V3

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf Cigna is providing claim administration services.

HC-DFS8

04-10

V1

Essential Health Benefits

Essential health benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in



at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

HC-DFS411

01-11

Expense Incurred

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

HC-DFS10

04-10
V1

Free-Standing Surgical Facility

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

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

HC-DFS11

04-10
V1

Hospice Care Program

The term Hospice Care Program means:

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

- a program for persons who have a Terminal Illness and for the families of those persons.

HC-DFS51

04-10
V1

Hospice Care Services

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

HC-DFS52

04-10
V1

Hospice Facility

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

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

HC-DFS53

04-10
V1

Hospital

The term Hospital means:

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



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

HC-DFS806

12-15

Hospital Confinement or Confined in a Hospital

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

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

HC-DFS807

12-15

Injury

The term Injury means an accidental bodily injury.

HC-DFS12

04-10

V1

Maximum Reimbursable Charge - Medical

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

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

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

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

HC-DFS792

05-15

V1

Medicaid

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

HC-DFS16

04-10

V1

Medical Pharmaceutical

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

HC-DFS848

10-16

Medically Necessary/Medical Necessity

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

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



supplies, medications or settings when determining least intensive setting.

HC-DFS839

10-16

Medicare

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

HC-DFS17

04-10
V1

Necessary Services and Supplies

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

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

HC-DFS21

04-10
V1

New Prescription Drug Product

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

HC-DFS850

10-16

Nurse

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

HC-DFS22

04-10
V1

Other Health Care Facility/Other Health Professional

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

HC-DFS23

04-10
V1

Participating Provider

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

HC-DFS45

04-10
V1

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

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

HC-DFS412

01-11



Pharmacy & Therapeutics (P&T) Committee

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

HC-DFS852

10-16

Physician

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

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

HC-DFS25

04-10

V1

Prescription Drug List

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

HC-DFS854

10-16

Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products

marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the plan, this definition also includes:

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

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

HC-DFS855

10-16

Prescription Order or Refill

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

HC-DFS856

10-16

Primary Care Physician

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

HC-DFS40

04-10

V1

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are



required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

HC-DFS26

04-10
V1

Review Organization

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

HC-DFS808

12-15

Sickness – For Medical Insurance

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

HC-DFS50

04-10
V1

Skilled Nursing Facility

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

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

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

HC-DFS31

04-10
V1

Specialist

The term Specialist means a Physician who provides specialized services, and is not engaged in general practice,

family practice, internal medicine, obstetrics/gynecology or pediatrics.

HC-DFS33

04-10
V1

Specialty Prescription Drug Product

A Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Medical Pharmaceutical has a high acquisition cost; and, whether the Medical Pharmaceutical is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-DFS858

10-16

Stabilize

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

HC-DFS413

01-11

Terminal Illness

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

HC-DFS54

04-10
V1



Therapeutic Alternative

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

HC-DFS859

10-16

Therapeutic Equivalent

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

HC-DFS860

10-16

Urgent Care

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

HC-DFS34

04-10

V1

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Exhibit D

JA-389

Case 3:25-cv-00498-SRU
Cigna Health and Life Insurance Company
SCRANTON CLAIM OFFICE
P.O. BOX 182223
CHATTANOOGA TN 37422-7223

Document 36-6

Filed 01/12/26

Page 2 of 4

000311

Cigna Health and Life Insurance Company
AS AGENT FOR:
UNILEVER UNITED STATES INC



Provider Number:
474541206 0016

Date through which claims were processed:
AUGUST 24, 2024

Remittance Tracking Number:

How to Contact Us

★ Mail to the return address in upper left corner of this page

➔ <http://www.cigna.com>

↑ Phone: (800) 244-6224

RICHARD L AGAG MD
456 WASHINGTON ST APT 8E
NEW YORK NY 10013-1554

Provider Explanation of Medical Benefits

Understanding this Benefits Statement

- ☞ This page provides a summary of the payments made this period.
- ☞ The accompanying pages give more detail on the claims we processed for this period.
Please review both the front and back of each page to see how the benefit amounts shown in the Explanation of Medical Benefits Report were determined.

In the event a claim is denied.....

Rights of Review and Appeal - For Physician or Health Care Provider

- ☞ If you have questions or disagree with the payment identified on this Explanation of Medical Benefits statement, you may ask to have it reviewed.
- ☞ If you have a contractual agreement with Cigna HealthCare, please refer to the procedural guidelines associated with your Cigna HealthCare contract, or call our office for assistance.

Federal Rights of Review and Appeal - For Employee

Call Member Services at the toll free number on this Explanation of Benefits (EOB) or your ID card if you have questions regarding this EOB.

If you're not satisfied with this coverage decision, you can start the Appeal process by submitting a written request to the address listed in your plan materials within 180 days of receipt of this EOB (unless a longer time is permitted by state law or your plan).

Send a copy of this EOB along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. Contact Member Services if you need further instructions on how and where to send your request for review.

Be sure to include your 1) Name, 2) Operation Location/Group Number, 3) Employee/Patient ID number, 4) Name of the patient and relationship, and 5) "Attention: Appeals Unit" on all supporting documents.

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

You will be notified of the final decision in a timely manner, as described in your plan materials. If your plan is governed by ERISA, you also have the right to bring legal action under section 502(a) of ERISA following our review.

Provider Summary

No Payment was made with this statement

The charges submitted were negated or offset by the deductibles, coinsurance, etc., or the patient(s) may be incurring liability for payment. See the following provider detail page for an explanation of how the benefits were determined.

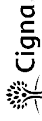
JA-390

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Definitions of terms used on the Provider Explanation of Medical Benefits Report section of this statement

Line:	Line item number.
Procedure Date:	Date you provided the service.
Procedure Code:	Code describing the service provided.
Adjusted Procedure Code:	Re-assigned procedure code (See Note).
Billed Amount:	Dollar amount you charged for service.
Adjusted Procedure Code Amount:	Dollar amount due to adjusted procedure code.
Allowed Amount:	Dollar amount covered by benefit plan.
Not Covered / Discount:	Part of "Billed Amount" Not Covered under the benefit plan or a Provider Discount.
Deduct / Copay Amount:	Portion of billed amount applied toward patient's deductible or copay (if any).
Coinsurance Amount:	The amount of the patient's coinsurance liability.
DRG / Per Diem / APC Type:	DRG (Diagnosis Related Group) / Per Diem / APC (Ambulatory Payment Classification) Category.
DRG / Per Diem / APC Number:	DRG (Diagnosis Related Group) /Per Diem / APC (Ambulatory Payment Classification) Code describing the service provided.
DRG / Per Diem Amount:	Dollar amount for DRG (Diagnosis Related Group) / Per Diem service provided.
DRG / Per Diem Benefit Amount:	Dollar amount payable by the benefit plan for DRG (Diagnosis Related Group) /Per Diem services.
Plan Benefit:	Dollar amount payable for services provided.
See Note:	If a portion or all of the charge is Not Covered, this is the written explanation of why it is Not Covered.
Other Insurance Paid:	The amount of another insurance carrier's payment.

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Provider Explanation of Medical Benefits Report

Provider Number 474541206 0016		Provider Name RICHARD L AGAG MD			Date through which claims were processed 08/24/2024				THIS IS NOT A BILL Retain for Your Records				Page 1	
Line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Not Covered/Discount	Deduct/Copay Amount	Coinsurance Amount	DRG / Per Diem / APC Type	DRG / Per Diem / APC Number	DRG/Per Diem Benefit Amount	Plan Benefit	See Note
Reminder: A coverage determination, prior authorization, or certification that is made prior to a service being performed is not a promise to pay for the service at any particular rate or amount. The patient's summary plan description governs amount payable, as every claim submitted is subject to all plan provisions, including, but not limited to, eligibility requirements, exclusions, limitations, and applicable state mandates.														
PATIENT NAME: M P PATIENT#: OPERATION LOCATION/GROUP# 56312-9-2500523 RECEIVE DATE: 08/09/2024 PROCESS DATE: 08/24														
PATIENT'S RELATIONSHIP TO SUBSCRIBER: SUBSCRIBER PROVIDER NETWORK STATUS: OUT OF NETWORK REF#: 468242201002														
SUBSCRIBER NAME: SUBSCRIBER#:														
1	01072022	1072022 2068		102285.00			102285.00					0.00	0.00	A0
2	01072022	1072022 32900		31752.40			31752.40					0.00	0.00	A0
3	01072022	1072022 38530		12556.60			12556.60					0.00	0.00	A0
4	01072022	1072022 11971		10671.40			10671.40					0.00	0.00	A0
5	01072022	1072022 15002		7700.00			7700.00					0.00	0.00	A0
6	01072022	1072022 19316		17396.20			17396.20					0.00	0.00	A0
7	01072022	1072022 35703		9226.40			9226.40					0.00	0.00	A0
8	01072022	1072022 35703		9226.40			9226.40					0.00	0.00	A0
TOTAL				200814.40			200814.40					0.00	0.00	
BALANCE..... \$200,814.40														
** NOTES ON BENEFIT DETERMINATION:														
IF YOU HAVE ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE REFERENCE NUMBER ON INQUIRIES.														
SYS-558														
VIEW ELIGIBILITY, BENEFITS, AND CLAIM DETAILS AND GET PRECERTIFICATION ANSWERS FAST AT THE CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE (WWW.CIGNAFORHCP.COM)														
A0) CUSTOMER: THIS OUT-OF-NETWORK CLAIM WAS SENT TOO LATE. THEREFORE, THE CLAIM WAS DENIED AND YOU MUST PAY THE CLAIM. IF YOU HAVE PROOF THAT YOU SENT IT ON TIME, PLEASE RESUBMIT THE CLAIM ALONG WITH THE PROOF TO THE ADDRESS ON THE BACK OF YOUR CIGNA ID CARD. FOR MORE INFORMATION ON CLAIM-FILING DEADLINES PLEASE REFER TO YOUR PLAN BOOKLET.														

BALANCE..... \$200,814.40

** NOTES ON BENEFIT DETERMINATION:

IF YOU HAVE ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE REFERENCE NUMBER ON INQUIRIES.

SYS-858

VIEW ELIGIBILITY, BENEFITS, AND CLAIM DETAILS AND GET PRECERTIFICATION ANSWERS FAST AT THE CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE (WWW.CIGNA.FORHCP.COM)

A0) CUSTOMER: THIS OUT-OF-NETWORK CLAIM WAS SENT TOO LATE. THEREFORE, THE CLAIM WAS DENIED AND YOU MUST PAY THE CLAIM. IF YOU HAVE PROOF THAT YOU SENT IT ON TIME, PLEASE RESUBMIT THE CLAIM ALONG WITH THE PROOF TO THE ADDRESS ON THE BACK OF YOUR CIGNA ID CARD. FOR MORE INFORMATION ON CLAIM-FILE DEADLINES PLEASE REFER TO YOUR PLAN BOOKLET.

G2433C 04-08-2015

PROCLAIM Provider Checkless EOP Summary

JA-392

Case 3:25-cv-00498-SRU Document 39 Filed 02/16/26 Page 1 of 10

**UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT**

----- X
RICHARD AGAG, MD,
:

Plaintiff,
:

v.
:

CIGNA HEALTH AND LIFE INSURANCE
COMPANY,
:

Defendant.
:
X

Case No.: 3:25-cv-00498-SRU

February 16, 2026

**PLAINTIFF'S REPLY MEMORANDUM IN FURTHER SUPPORT OF PLAINTIFF'S
CROSS-MOTIONS TO CONFIRM AND/OR FOR SUMMARY JUDGMENT**

Respectfully submitted,

MERIN LAW, LLC
Attorneys for Plaintiff

By: /s/ Clifford A. Merin, Esq., 29863
Clifford A. Merin
Merin Law, LLC
51 Elm Street, Suite 409
New Haven, CT 06510
475.321.4101
clifford@merinlaw.com

GOTTLIEB & GREENSPAN, LLC

By: /s/ James Greenspan
James Greenspan
17-17 Route 208, Suite 250
Fair Lawn, New Jersey 07410
(201) 644-0894
jgreenspan@gottliebandgreenspan.com

ORAL ARGUMENT REQUESTED

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Plaintiff Richard Agag, MD (“Plaintiff”) respectfully submits this Memorandum of Law in further support of Plaintiff’s Cross-Motions to Confirm and/or for Summary Judgment (“Cross-Motions”).

PRELIMINARY STATEMENT

As a result of Defendant’s refusal to abide by its legal obligation to pay the awards issued under the Independent Dispute Resolution (“IDR”) process of the Federal No Surprises Act (“NSA”), Plaintiff commenced this action. The undisputed facts demonstrate that the Awards were issued in Plaintiff’s favor pursuant to IDR dispute DISP-878778, DISP-2001877, DISP-2001876, DISP-2001874, and DISP-2001871 (the “Awards”), and that Defendant has refused to pay the Awards. Further, Defendant has not moved to vacate any of the Awards and there is no legal basis to support any result other than confirmation or judgment in this matter.

Defendant, who has failed to satisfy its obligations under federal law and disregarded every opportunity to seek a vacatur of the Awards has effectively asked this Court to sanction its violation of federal law in the absence of a *mandatory* alternative confirmation mechanism. After unilaterally deciding that it did not have to pay any of the Awards, effectively taking the law into its own hands, Defendant now asks this Court to conduct a fulsome review of the underlying IDR process. Defendant’s request is entirely inappropriate and must be disregarded.

LEGAL ARGUMENT

POINT I: DEFENDANT IS IN DEFAULT OF ITS LEGAL OBLIGATIONS UNDER FEDERAL LAW AND NO GENUINE ISSUE OF MATERIAL FACTS EXIST

It is undisputed that Defendant has failed to issue payment to Plaintiff for any of Awards. *See* Defendant’s Rule 56 (A) 2 Statement ¶ 14 (“Undisputed”). Rather than satisfy its legal obligations under federal law, Defendant argues that the CPT codes at issue were not covered under the Defendant’s plan, and therefore were not eligible for the IDR process under the terms of the NSA.

Defendant's argument, based entirely on this misplaced theory, is without merit.

Having failed to timely move to vacate any of the Awards, Defendant seeks to oppose Plaintiff's Cross-Motions by raising the arguments that are appropriate for a motion to vacate. Defendant essentially argues that the IDR entities acted in disregard of the law by issuing the Awards based on denied claims and, therefore, not subject to the NSA. This argument goes to the heart of a motion to vacate and is entirely improper in support of Defendant's Motion to Dismiss or in opposition to Plaintiff's Cross-Motions.

For DISP-878778, and in accordance with the IDR process, Plaintiff and Defendant **both** submitted their final offers to the certified IDR entity ("CIDREs") after which the CIDRE entered a final determination. The remaining disputes, Plaintiff prevailed without Defendant's participation. *See* Exhibits A, B, C, D, E to Complaint, the Awards:

- In DISP-878778, Plaintiff submitted a final offer of \$97,500.00 while Defendant submitted a final offer of \$421.25. *See* the Award, Exhibit A to Complaint. On March 6, 2024, the CIDRE entered an award in Plaintiff's favor in the amount of \$97,500.00, which Defendant has failed to pay. *Id.*
- In DISP-2001877, Plaintiff submitted a final offer of \$5,535.84, while Defendant did not participate. *See* the Award, Exhibit B to Complaint. On December 19, 2024, the CIDRE entered an award in Plaintiff's favor in the amount of \$5,535.84, which Defendant has failed to pay. *Id.*
- In DISP-2001876, Plaintiff submitted a final offer of \$5,535.84, while Defendant did not participate. *See* the Award, Exhibit C to Complaint. On December 19, 2024, the CIDRE entered an award in Plaintiff's favor in the amount of \$5,535.84, which Defendant has failed to pay. *Id.*
- In DISP-2001874, Plaintiff submitted a final offer of \$7,700.00, while Defendant did not participate. *See* the Award, Exhibit D to Complaint. On December 19, 2024, the CIDRE entered an award in Plaintiff's favor in the amount of \$7,700.00, which Defendant has failed to pay. *Id.*
- In DISP-2001871, Plaintiff submitted a final offer of \$26,296.31, while Defendant did not participate. *See* the Award, Exhibit E to Complaint. On December 19, 2024, the CIDRE entered an award in Plaintiff's favor in the amount of \$26,296.31, which Defendant has failed to pay. *Id.*

For each of the disputes and, in accordance with federal guidelines, the CIDRE maintained and heard the disputes, considered the final offers, and issued the Awards.¹ The “Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities” provides as follows:

4.4 Instances When the Non-Initiating Party Believes That the Federal IDR Process Does Not Apply

If the non-initiating party believes that the Federal IDR Process is not applicable, the non-initiating party must notify the Departments by submitting the relevant information through the Federal IDR portal as part of the certified IDR entity selection process. This information must be provided no later than 1 business day after the end of the 3-business-day period for certified IDR entity selection, (the same date that the notice of selection or failure to select a certified IDR entity must be submitted). This notification must include information regarding the Federal IDR Process’ inapplicability. *The certified IDR entity must determine whether the Federal IDR Process is applicable.* The certified IDR entity must review the information submitted in the Notice of IDR Initiation and the notification from the non-initiating party claiming the Federal IDR Process is inapplicable, if one has been submitted, to determine whether the Federal IDR Process applies. If the certified IDR entity determines that the Federal IDR Process does not apply, the certified IDR entity must notify the Departments and the parties within 3 business days of making that determination, as described in Section 4. Further, the Departments will maintain oversight of the applicability of the Federal IDR Process through their audit authority.² (Emphasis added).

Additionally, “the certified IDR entity must determine whether the Federal IDR Process applies to the items and services that are the subject of the dispute” *Id.* at 4.6.2. Here, each dispute was maintained and heard by the CIDREs. The CIDREs contemplated the submissions and final offers submitted by *both* parties pursuant to DISP-878778, contemplated the submission by Plaintiff only in the remaining disputes, and adjudicated each of the disputes in Plaintiff’s favor. *See* Exhibit A to Complaint.

¹In fact, the only notation of an objection in DISP-878778 is that Defendant “objected to not receiving the Open Negotiation Notice for the Dispute” and that objection was overruled based on the determination that the “Open Negotiation period and the submission of the Notice were within CMS time frames” *See* Award DISP-878778 pg. 3, Exhibit A to Complaint, the Award.

² <https://www.cms.gov/files/document/federal-idr-guidance-idr-entities-march-2023.pdf>.

Defendant participated in the IDR process for DISP-878778, had the opportunity to participate in the remaining disputes and failed to do so, the CIDREs found in Plaintiff's favor for each of the Awards, Defendant failed to pay the Awards, and Defendant has failed to move to vacate any of the Awards.

Defendant has opted to sit back and wait for Plaintiff to seek enforcement rather than avail itself of the mechanisms in place and seek vacatur of the Awards. Defendant's efforts to avoid its legal obligations through a motion to dismiss are entirely improper, and contrary to long-standing precedence, which preclude a Court from conducting a fulsome review of the underlying disputes and resulting IDR process. Awards as generated through the IDR process, are "final and binding" and are only to be disturbed under very limited circumstances. *See EB Safe, LLC v. Hurley*, 832 F. App'x 705, 707 (2d Cir. 2020) ("[A]rbitration awards are subject to very limited review in order to avoid undermining the twin goals of arbitration, namely, settling disputes efficiently and avoiding long and expensive litigation. . . . The Federal Arbitration Act (FAA) creates a 'strong presumption in favor of enforcing arbitration awards,' and courts have an 'extremely limited' role in reviewing such awards."); *See* Sections 10(a)(3) and (4) of the FAA (concerning vacatur), which are expressly incorporated in the NSA. This might explain why Defendant has not moved to vacate any of the Awards. Moreover, enforcement of IDR awards is entirely consistent with the purpose of the "legislative scheme" which mandated that the awards are "final and binding." If the Awards cannot be enforced, the legislative scheme is rendered meaningless.

Defendant's statement that it is "undisputed" that the Awards have not been paid is the crux of the entirety of this action. *See* Defendant's Rule 56 (A) 2 Statement ¶ 14. The ancillary information Defendant has submitted in response to Plaintiff's 56 (A) 1 statement, and in its "additional material facts" concerning the underlying plans, explanation of benefits, billing procedures, and coverage issues

are all irrelevant to the issues presented to this Court. Plaintiff initiated the IDR processes, Defendant participated or had the opportunity to participate, Plaintiff achieved each of the Awards, and Defendant has failed to pay. Defendant remains in default of its legal obligation to pay the Awards in violation of the NSA and it is undisputed that Defendant has failed to pay. Therefore, Plaintiff's Cross-Motion to Confirm should be granted or, in the alternative, Plaintiff's Cross-Motion for Summary Judgment should be granted (as no genuine issue of material fact exists and Defendant is in violation of the NSA) and Defendant's Motion to Dismiss should be denied.³

**POINT II: DEFENDANT MISCHARACTERIZES CASE LAW IN SUPPORT OF
PLAINTIFF'S POSITION**

Defendant continues to cast aside the Court's decision in *Guardian Flight LLC v. Aetna Life Insurance Co.*, 2025 U.S. District LEXIS 91676 (D. Conn. May 14, 2025) which held that a private right of action exists under the NSA. *See* Plaintiff's Opposition to Motion to Dismiss, pg. 13. Defendant's insistence that a text order from September 30, 2025, concerning the Court's denial of the Defendant's request to file an interlocutory appeal somehow diminishes the Court's findings of a private right of action under the NSA is without merit. Although the Court did indicate that it was "possible" a different conclusion could have been reached concerning a private right of action, the text order did not change or in any way vacate the Court's previous ruling that a private right of action exists under the NSA.

Defendant further argues that Plaintiff's reliance on *GPS of N.J. M.D. v. Horizon Blue Cross & Blue Shield*, No. 22-06614 (KM), 2023 U.S. Dist. EXIS 159460, at *24 (D.N.J. Sept. 8, 2023) and *Worldwide Aircraft Servs. Inc. v. Worldwide Ins. Servs., LLC*, No. 8:24-cv-00840 (TPB), 2024 U.S.

³As articulated in Plaintiff's Opposition to Defendant's Motion to Dismiss and Cross-Motions to Confirm and/or for Summary Judgment, Plaintiff is not seeking confirmation of the Award pursuant to DISP-878778; rather, Plaintiff seeks judicial enforcement pursuant to its claim that Defendant is in violation of the NSA, as described in Plaintiff's Cross-Motion for Summary Judgment.

Dist. LEXIS 167943, at *9–10 (M.D. Fla. Sept. 8, 2024) is misplaced in that the courts in each of these cases “perfunctorily granted motions to confirm ... awards.” *See* Def.’s Opposition, pg. 14.

In *GPS*, the Court’s analysis focused on whether the IDR award at issue should be vacated pursuant to Sections 10(a)(3) and (4) of the FAA, which are expressly incorporated in the NSA. *GPS*, 2023 US Dist. LEXIS 159460 at *3-4. *GPS* filed a motion to vacate the award pursuant to Sections 10(a)(3) and (4) of the FAA. However, Horizon did not merely oppose *GPS*’ Motion; Horizon filed a cross-motion seeking to confirm the award. Therefore, Defendant’s assertion that this was merely a “perfunctory” ruling is disingenuous. To wit, the Honorable Kevin McNulty, U.S.D.J. wrote:

[U]nless the arbitration award is vacated pursuant to Section 10 or modified or corrected under Section 11 of the FAA, the award “must” be confirmed. In interpreting 9 U.S.C. § 9, “language that indicates the award will be final and binding implicitly permits Federal court intervention to compel compliance.” *New Jersey Bldg. Laborers’ Statewide Ben. Funds v. Newark Bd. of Educ.*, No. 12-cv-7665, 2013 U.S. Dist. LEXIS 131088, at *3 (D.N.J. Sept. 13, 2013) (quoting *Teamsters–Employer Local No. 945 Pension Fund v. Acme Sanitation Corp.*, 963 F. Supp. 340, 347 (D.N.J.1997)). In this case, the Act provides that any determination of the IDR entity is binding on the parties and is only subject to judicial review under the circumstances described in Section 10(a) of the Federal Arbitration Act, 9 U.S.C. § 10. § 300gg-111(c)(5)(E). That language indicates the decision is to be “final and binding,” and gives the court the authority to confirm the award. *GPS*, 2023 US Dist. LEXIS 159460 at *24.

In other words, Judge McNulty interprets the interplay of the FAA and NSA as one in which 9 U.S.C. § 9 absolutely applies and can be used to confirm the award “unless the arbitration award is vacated pursuant to Section 10” In that way, *GPS* sanctions the application of 9 U.S.C. § 9 as equally (if not more) applicable to the NSA than Section 10.

In *Worldwide Aircraft*, a petition to confirm “arbitration award” was filed following an IDR award. The Defendant also filed a motion to vacate the award. In its analysis and ruling, the court confirmed the award and stated “[t]he result of [the defendant’s] business decisions, ***together with applicable law***, and considerations of justice and fair play, is that [the defendant] must pay the arbitration award entered against it” (emphasis added.) *Worldwide Aircraft Servs. Inc. v.*

Worldwide Ins. Servs., LLC, No. 8:24-CV-840-TPB-CPT, 2024 U.S. Dist. LEXIS 167943, at *9 (M.D. Fla. Sep. 18, 2024). Although the decisions in *GPS* and *Worldwide Aircraft* may not be consistent with Defendant's arguments, that does not mean the courts' decisions and reasonings were merely "perfunctory."

Based on the plain language of the NSA and Defendant's failure to pay legally binding Awards, Plaintiff's Motion to Confirm should be granted and/or summary judgment should enter for Plaintiff.

CONCLUSION

For the foregoing reasons, Plaintiff respectfully requests that this Court deny Defendant's Motion to Dismiss in its entirety and grant Plaintiff's Cross-Motions.

Dated: February 16, 2026

MERIN LAW, LLC

By: /s/ Clifford A. Merin, Esq., 29863

Clifford A. Merin, Esq.
51 Elm Street, Suite 409
New Haven, CT 06510
475.321.4101
clifford@merinlaw.com

GOTTLIEB & GREENSPAN, LLC

By: /s/ James Greenspan

James Greenspan, Esq.
17-17 Route 208
Suite 250
Fair Lawn, New Jersey 07410
(201) 644-0894
jgreenspan@gottliebandgreenspan.com

Attorneys for Plaintiff

JA-402

**EXHIBIT A TO COMPLAINT -
CIDRE, FEDERAL HEARINGS AND APPEALS SERVICES, INC.'S RULING,
DISP-878778, DATED MARCH 6, 2024
(REPRODUCED HEREIN AT PP. JA-19 – JA-23)**

**EXHIBIT B TO COMPLAINT -
CIDRE, PROPEER RESOURCES, LLC'S RULING,
DISP-2001877, DATED DECEMBER 19, 2024
(REPRODUCED HEREIN AT PP. JA-24 – JA-26)**

**EXHIBIT C TO COMPLAINT -
CIDRE, PROPEER RESOURCES, LLC'S RULING,
DISP-2001876, DATED DECEMBER 19, 2024
(REPRODUCED HEREIN AT PP. JA-27 – JA-29)**

**EXHIBIT D TO COMPLAINT -
CIDRE, PROPEER RESOURCES, LLC'S RULING,
DISP-2001874, DATED DECEMBER 19, 2024
(REPRODUCED HEREIN AT PP. JA-30 – JA-32)**

**EXHIBIT E TO COMPLAINT -
CIDRE, PROPEER RESOURCES, LLC'S RULING,
DISP-2001871, DATED DECEMBER 19, 2024
(REPRODUCED HEREIN AT PP. JA-33 – JA-35)**

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

**Richard Agag, MD,
Plaintiff,**

v.

**Cigna Health and Life Insurance
Company,
Defendant.**

No. 3:25-cv-00498 (SRU)

ORDER ON MOTION TO DISMISS AND CROSS-MOTION TO CONFIRM

The plaintiff, Richard Agag, is a physician specializing in plastic and reconstructive surgery. He alleges that he has not been reimbursed by the defendant, Cigna Health and Life Insurance Company (“Cigna”), for out-of-network services he provided to two patients who were insured by Cigna. He seeks an order confirming various awards in his favor that resulted from the independent dispute resolution (“IDR”) process outlined in the No Surprises Act (“NSA”). In response, Cigna moves to dismiss his complaint on the grounds that Agag does not have a private right of action to seek confirmation of those awards in federal court and that I do not have subject matter jurisdiction to decide this case.

My decision represents the third time that a judge in the District of Connecticut has weighed in on whether a health care provider may seek confirmation in federal court of an NSA IDR award when a health insurance company refuses to pay that award. The first concluded that the NSA provides an implied private right of action for providers to seek confirmation in federal court. *See Guardian Flight LLC v. Aetna Life Ins. Co.*, 789 F. Supp. 3d 214 (D. Conn. 2025). The second concluded that it lacked subject matter jurisdiction over the case because neither the Federal Arbitration Act (“FAA”) nor the NSA provides any basis for a provider to seek confirmation in federal court. *See Axis Neuromonitoring, LLC v. Aetna Inc.*, 2026 WL 795260

(D. Conn. Mar. 20, 2026). In doing so, it largely agreed with the Fifth Circuit, the only appellate court so far to rule on the issues presented in this case. *See Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th 271 (5th Cir. 2025). Today, I reach a third conclusion: that I have federal question jurisdiction under the NSA, and that a provider may seek confirmation of an IDR award in federal court under the NSA, but not the FAA, because the requested relief can be provided through a summary proceeding that does not involve a traditional private right of action or judicial review.

For the following reasons, Cigna’s Motion to Dismiss, Doc. No. 25, is **GRANTED** with regard to Agag’s request to confirm the IDR award under the FAA and his request for damages under the NSA, but **DENIED** otherwise. Agag’s Cross-Motion to Confirm, Doc. No. 33, is **GRANTED**.

I. Background

A. The No Surprises Act

The No Surprises Act (“NSA”) protects medical patients from “surprise medical bills” that may arise when a patient receives emergency medical care from an out-of-network health care provider or non-emergency medical care from an out-of-network provider at an in-network health care facility. 42 U.S.C. § 300gg-111, et seq. The NSA does so by prohibiting out-of-network providers from holding patients liable for more than a patient’s in-network cost-sharing responsibility. *Id.* §§ 300gg-131, -132. If a provider bills a patient an amount greater than their in-network cost-sharing responsibility, the provider must “reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost-sharing amount for the treatment or services involved, plus interest, at an interest rate determined by the Secretary [of Health and Human Services].” *Id.* § 300gg-139(b).

A physician seeking reimbursement for costs in excess of the in-network cost-sharing amount paid by the patient must submit a claim directly to the patient's health insurance plan. *Id.* §§ 300gg-111(b)(1)(C)-(D). The health insurance company administering that plan then has 30 days either to render an initial payment or to issue a notice of claim denial. *Id.* § 300gg-111(a)(1)(C)(iv)(I). If an out-of-network provider disagrees with the payment amount or the denial of the claim, the provider may, during the 30-day period beginning on the day the provider receives an initial payment or claim denial, initiate "open negotiations" with the health insurance company to determine the appropriate reimbursement amount. *Id.* § 300gg-111(c)(1).

i. The IDR Process

If open negotiations do not conclude in an agreement between the provider and the health insurance company, either side "may, during the 4-day period beginning on the day after such open negotiation period, initiate the independent dispute resolution process" laid out under the NSA. *Id.* § 300gg-111(c)(1)(B). The IDR entity selected for the dispute must, within 30 days of being selected, choose between the two payment-amount offers individually submitted by the provider and the health insurance company. *Id.* § 300gg-111(c)(5)(A). After the IDR entity determines the appropriate award, a health insurance company must pay the award "directly to the [provider] not later than 30 days after the date on which such determination is made." *Id.* § 300gg-111(c)(6).

In deciding which offer to select, an IDR entity must consider a variety of factors. *See id.* § 300gg-111(c)(5)(C). Among those factors is the "qualifying payment amount," which generally refers to "the median of the contracted rates recognized by the [health insurance] plan or issuer . . . for the same or a similar item or service that is provided by a provider in the same or similar specialty and provided in the geographic region in which the item or service is furnished[.]" *Id.* § 300gg-111(a)(3)(E)(i)(I). The IDR entity uses that calculation when it

assesses which offer to select during the IDR process, meaning that the “qualifying payment amount” may differ from the payment determination ultimately made by the IDR entity. *See id.* § 300gg-111(c)(7)(A)(v) (suggesting that “the payment amount determined (or agreed to)” may “exceed[] the qualifying payment amount”). Indeed, a health insurance company does not necessarily need to submit the “qualifying payment amount” calculation as its offer during the IDR process. *See id.* § 300gg-111(c)(7)(B)(iii) (noting that “the amount of the offer submitted . . . by the group health plan or health insurance issuer” may be “a percentage of the qualifying payment amount”). Put differently, the qualifying payment amount is the amount a health insurance company reasonably *should* pay when an out-of-network provider makes a claim for services covered by the NSA.

The NSA states that the IDR entity’s determination:

- (I) shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim; and
- (II) shall not be subject to judicial review, except in a case described in any of the paragraphs (1) through (4) of section 10(a) of title 9.

Id. § 300gg-111(c)(5)(E)(i). Section 300gg-111(c)(5)(E)(i)(II) of the NSA references 9 U.S.C. § 10(a), which is part of the FAA. The FAA governs arbitration agreements and the arbitral process. *See* 9 U.S.C. § 1, et seq. An arbitration agreement is generally defined under the FAA as “[a] written provision . . . to settle by arbitration” a dispute that arises between the parties. *Id.* § 2. The FAA deems written arbitration agreements to be valid unless certain exceptions apply. *See id.* The FAA also authorizes federal courts to enter an arbitration award into judgment when “the parties in their agreement have agreed that a judgment of the court shall be entered upon the award made pursuant to arbitration.” *Id.* § 9. A federal court, however, is not required to confirm an arbitration award and enter judgment. A court may, under Section 10(a), vacate an arbitration award under the following circumstances:

- (1) where the award was procured by corruption, fraud, or undue means;
- (2) where there was evident partiality or corruption in the arbitrators, or either of them;
- (3) where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced; or
- (4) where the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made.

Id. § 10(a).

ii. Administrative Framework

The NSA empowers the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury to oversee much of the independent dispute resolution (“IDR”) process. 42 U.S.C. § 300gg-111(c)(2)(A). For instance, the NSA instructs those three Secretaries to “establish a process to certify” IDR entities that will mediate the process. *Id.* § 300gg-111(c)(4)(A). Parties that engage in the IDR process may either select their own IDR entity or have the Department of Health and Human Services (“HHS”) appoint an IDR entity. *Id.* § 300gg-111(c)(4)(F).

If the health insurance company fails to pay the IDR award to the provider within 30 days of the IDR entity’s determination, the NSA authorizes HHS to impose civil monetary penalties on the company. *Id.* § 300gg-22(b)(2)(C). A health insurance company that disputes the civil monetary penalty may seek a hearing before HHS, *id.* § 300gg-22(2)(D), and—after that administrative hearing—a review of the penalty by a federal district court. *Id.* § 300gg-22(b)(2)(E)(i). If a health insurance company does not request a hearing before the HHS, the civil monetary penalty “shall constitute a final and unappealable order.” *Id.* § 300gg-22(2)(D)(i). When a health insurance company still does not pay the penalty “after it has become a final and unappealable order, or after [a federal district court] has entered final judgment in favor of

[HHS],” HHS “shall” refer the matter to the Attorney General, who “shall recover” the penalty “in the appropriate United States District court.” *Id.* § 300gg-22(b)(2)(F)(i).

In addition, the NSA instructs HHS to establish several rules. For instance, it orders HHS to create an audit process to ensure that health insurance companies “are in compliance with the requirement of applying a qualifying payment amount” under the NSA. *Id.* § 300gg-111(a)(2)(A)(i). That process is intended to ensure that health insurance companies are using the qualifying payment amount calculation when they process claims made under the NSA. It does not address whether those amounts are actually paid out to providers.

The NSA also requires HHS to establish “a process to receive complaints of violations” of the statute. *Id.* § 300gg-111(a)(2)(B)(iv); *see also id.* § 300gg-134(b)(3) (instructing HHS to “establish a process to receive consumer complaints of violations . . . and provide a response to such complaints within 60 days of receipt of such complaints”). Accordingly, HHS has set up a “No Surprises Help Desk” that is administered, at least in part, by the Center for Medicare and Medicaid Services (“CMS”). *See No Surprises Act: How to Get Help and File a Complaint*, Center for Medicare and Medicaid Services (Aug. 2023), <https://www.cms.gov/files/document/nsa-helpdesk.pdf>. Providers who wish to report a violation of the NSA may contact the No Surprises Help Desk by phone or submit an online complaint. *See Providers: submit a billing complaint*, Center for Medicare and Medicaid Services (Feb. 4, 2026), <https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint>. The NSA does not prescribe what steps CMS takes to resolve a complaint submitted through the No Surprises Help Desk.

B. Factual Background

Agag is a physician who specializes in plastic and reconstructive surgery. Compl., Doc. No. 1, ¶ 5. He does not have a network contract with Cigna and is therefore an out-of-network

provider for patients who are the beneficiaries of health plans issued by or administered by Cigna. *Id.* ¶ 7. That includes the two patients relevant to this action. *Id.* ¶ 6. The services rendered by Agag to the two patients in this case were done so “emergently/inadvertently.” *Id.* ¶ 8.

On January 7, 2022, Agag performed surgery for Patient M.P. at Saint Mary’s Hospital in Waterbury, Connecticut. *Id.* ¶ 24. Following Patient M.P.’s treatment, Agag submitted four claims to Cigna: two for \$9,226.40 each, one for \$7,700.00, and one for \$31,752.40. *Id.* ¶¶ 25, 35, 45, 55. Cigna effectively denied all those claims. *Id.* ¶¶ 26, 36, 46, 56 (noting for all four claims that “Defendant allowed payment to Plaintiff in the amount of \$0.00”). Agag disputed Cigna’s payment determination and initiated open negotiations, which did not resolve the two parties’ payment dispute. *Id.* ¶¶ 27, 37, 47, 57. Consequently, Agag initiated the IDR process. *Id.* ¶¶ 28, 38, 48, 58.

On December 19, 2024, ProPeer Resources, LLC—the certified IDR entity assigned to evaluate those claims—ruled in Agag’s favor on all four claims, awarding \$5,535.84 each for the first two claims, \$7,700.00 for the third claim, and \$26,296.31 for the fourth claim. *Id.* ¶¶ 30 (describing Arbitration Dispute DISP-2001877), 40 (DISP-2001876), 50 (DISP-2001874), 60 (DISP-2001871). Cigna failed to pay any of those payment amounts within 30 days of the awards. *Id.* ¶¶ 32, 42, 52, 62. Agag claims that he still has not received payment for any of those awards. *Id.* ¶¶ 33, 43, 53, 63.

On April 14, 2023, Agag performed surgery on Patient M.L. at Backus Hospital in Norwich, Connecticut. *Id.* ¶ 13. Following the surgery, Agag submitted a claim to Cigna seeking \$196,000.00 in payment. *Id.* ¶ 14. Cigna responded by effectively denying the claim. *Id.* ¶ 15 (“Defendant allowed payment to Plaintiff in the amount of \$0.00.”). Agag subsequently

initiated an open negotiation period, which did not resolve the two parties' payment dispute. *Id.* ¶¶ 16-17. He then initiated the IDR process. *Id.* ¶ 17. On March 6, 2024, Federal Hearings and Appeals Services, Inc.—the certified IDR entity assigned to decide that dispute—ruled in Agag's favor and awarded \$97,500.00 to Agag under Arbitration Dispute DISP-878778. *Id.* ¶ 19. Cigna did not pay that payment amount within 30 days. *Id.* ¶ 21. Agag claims that he has still not received the \$97,500.00 owed to him. *Id.* ¶ 23.

Combined, the five IDR awards mean that Cigna owes Agag a total of \$142,567.99.

C. Procedural History

On March 27, 2025, Agag filed his complaint against Cigna. *See id.* In Count One, Agag requests an order confirming, under Section 9 of the FAA, the five IDR awards described above. *Id.* ¶¶ 66-71. In Count Two, Agag alleges that Cigna, by not paying him those awards, has violated the NSA and caused him \$142,567.99 in damages. *Id.* ¶¶ 72-79. Agag's complaint requests an order confirming the five IDR awards described above, as well as an order directing Cigna to pay the combined \$142,567.99 owed to him under those IDR awards. *Id.* at 11.

Cigna responded to Agag's Complaint by filing a motion to dismiss on September 26, 2025. *See* Def.'s Mot. to Dismiss, Doc. No. 25. Cigna makes two principal arguments in its motion. First, Cigna argues that the NSA does not provide a private right of action to seek judicial confirmation of IDR awards. Def.'s Mem. of L. in Supp. of Mot. to Dismiss Pl.'s Compl., Doc. No. 25-1, at 1-2. In doing so, Cigna asserts that it lacks subject matter jurisdiction over this case and that Agag fails to state a claim upon which relief can be granted. *See id.* at 11. Secondly, Cigna argues that even if the NSA did provide a private right of action under 9 U.S.C. § 9, Agag has run out of time to request a judicial confirmation of the IDR award in Patient M.L.'s case, because 9 U.S.C. § 9 sets out a one-year time limit for confirmation of arbitration

awards, and the IDR award was made on March 6, 2024, more than a year before Agag filed his complaint. *Id.* at 2.

On November 21, 2025, Agag filed a Cross-Motion to Confirm. Pl.’s Mem. of L. in Opp’n to Def.’s Mot. to Dismiss Compl. and in Supp. of Pl.’s Cross-Mots. to Confirm and for Summ. J., Doc. No. 33. He emphasizes that under 9 U.S.C. § 9, a court must grant a petition to confirm an arbitration award unless Cigna has moved to vacate the awards, which it has not. *Id.* at 18.

II. Motion to Dismiss Under Rule 12(b)(1)

Agag claims that I have subject matter jurisdiction because the dispute “arises under” both the FAA and the NSA. In response, Cigna argues that Section 9 of the FAA does not apply to the facts of this case and that the NSA does not provide a private right of action for Agag to bring his case in federal court. Accordingly, Cigna moves to dismiss the case under Fed. R. Civ. P. 12(b)(1).

A. Legal Standard

“Customarily, a federal court first resolves any doubts about its jurisdiction over the subject matter of a case before reaching the merits or otherwise disposing of the case.” *Cantor Fitzgerald, L.P. v. Peaslee*, 88 F.3d 152, 155 (2d Cir. 1996). That is because “if [a court] must dismiss the complaint for lack of subject matter jurisdiction, the accompanying defenses and objections become moot and do not need to be determined.” *Rhulen Agency, Inc. v. Alabama Ins. Guar. Ass’n*, 896 F.2d 674, 678 (2d Cir. 1990) (internal citation omitted). “A case is properly dismissed for lack of subject matter jurisdiction under Rule 12(b)(1) when the district court lacks the statutory or constitutional power to adjudicate it.” *Makarova v. United States*, 201 F.3d 110, 113 (2d Cir. 2000). To survive a motion brought under Rule 12(b)(1), a plaintiff

“has the burden of proving by a preponderance of the evidence that [subject matter jurisdiction] exists.” *Id.* (citing *Malik v. Meissner*, 82 F.3d 560, 562 (2d Cir. 1996)).

“The federal courts are ‘courts of limited jurisdiction, defined (within constitutional bounds) by federal statute.’” *Trustees of New York State Nurses Ass’n Pension Plan v. White Oak Glob. Advisors, LLC*, 102 F.4th 572, 593-94 (2d Cir. 2024) (quoting *Badgerow v. Walters*, 596 U.S. 1, 7 (2022)). “Congress has granted those courts jurisdiction over two main kinds of cases.” *Badgerow*, 596 U.S. at 7 (2022). The first is when there is complete diversity of citizenship between the plaintiff and the defendant, and when the amount-in-controversy exceeds \$75,000. 28 U.S.C. § 1332(a). The second is when the plaintiff sets forth a colorable claim “arising under the Constitution, laws, or treaties of the United States.” 28 U.S.C. § 1331.

B. The FAA Does Not Provide a Basis for Jurisdiction

Agag argues that I have subject matter jurisdiction under the FAA. Section 9 of the FAA, however, does not by itself establish federal question jurisdiction. *Badgerow*, 596 U.S. at 8. Instead, for a federal court to have subject matter jurisdiction over a petition to confirm an arbitration award under Section 9, there must be a “jurisdictional basis independent of the FAA” that “appear[s] on ‘the face of the application itself.’” *White Oak Glob. Advisors, LLC*, 102 F.4th at 596 (quoting *Badgerow*, 596 U.S. at 9). Because the FAA cannot independently establish federal question jurisdiction and Section 9 of the FAA does not even apply to the facts of this case, *see infra* Section III(b), I conclude that the FAA cannot be a basis for federal question jurisdiction under 28 U.S.C. § 1331. *See also Axis Neuromonitoring, LLC*, 2026 WL 795260, at *4 (quoting *Badgerow*, 596 U.S. at 11).

C. The NSA Provides a Basis for Jurisdiction

I next turn to whether the NSA, standing alone, provides an independent basis for federal question jurisdiction. Cigna argues that a court cannot have subject matter jurisdiction to hear a case “arising under” the NSA because the NSA did not create a private right of action. I address that question in Section III(c) of this opinion. For purposes of the jurisdictional analysis, I will assume that the NSA does not create a private right of action for providers.

“Typically, an action arises under federal law if the law ‘creates the cause of action asserted.’” *Badgerow*, 596 U.S. at 7-8 (quoting *Gunn v. Minton*, 568 U.S. 251, 257 (2013)). That does not mean, however, that a federal cause of action is required for a court to have federal question jurisdiction. *Grable & Sons Metal Prods. Inc. v. Darue Eng’g & Mfg.*, 545 U.S. 308, 317 (2005). Indeed, “[i]t is firmly established . . . that the absence of a valid (as opposed to arguable) cause of action does not implicate subject-matter jurisdiction” *Steel Co. v. Citizens for a Better Env’t*, 523 U.S. 83, 89 (1998).

A federal court has jurisdiction “if the right of the petitioners to recover under their complaint will be sustained” under one construction of a federal law but not another, “unless the claim clearly appears to be immaterial and made solely for the purpose of obtaining jurisdiction or where such a claim is wholly insubstantial and frivolous.” *Id.* (cleaned up). Put differently, “[d]ismissal for lack of subject-matter jurisdiction because of the inadequacy of the federal claim is proper only when the claim is ‘so insubstantial, implausible, foreclosed by prior decisions of this Court, or otherwise completely devoid of merit as not to involve a federal controversy.’” *Id.* (quoting *Oneida Indian Nation of N.Y. v. County of Oneida*, 414 U.S. 661, 666 (1974)).

The jurisdictional inquiry under Section 1331 is therefore distinct from the right of action inquiry that Cigna focuses on. Under Section 1331, what matters is that the claim arises under federal law on the face of the well-pleaded complaint, *see generally Louisville & Nashville R.*

Co. v. Mottley, 211 U.S. 149 (1908), not whether the NSA expressly entitles relief to an aggrieved party. Here, Agag alleges that Cigna violated a federal statute—the NSA—and he does so on the face of his well-pleaded complaint. That alone is enough for me to conclude that I have federal question jurisdiction to hear this dispute.

Concluding otherwise would ignore the low bar that exists for federal question jurisdiction. Federal question jurisdiction may exist even when a state-law claim, rather than a federal-law one, is at issue. *Gunn v. Minton*, 568 U.S. 251, 258 (2013) (citing *Grable*, 545 U.S. at 314) (explaining that a court can have subject matter jurisdiction over a state-law claim if the state-law claim “necessarily raise[s] a stated federal issue, actually disputed and substantial, which a federal forum may entertain without disturbing any congressionally approved balance of federal and state judicial responsibilities”). I see no reason why a purely federal statute like the NSA—even if it may not provide a private right of action—should have less of a jurisdictional hook than some state-law claims. Hearing a dispute under the NSA does not implicate the sort of federalism concerns that a suit based exclusively on state-law claims would. In the absence of any proof that Congress wanted to insulate the NSA from any federal court involvement, I conclude that I have subject matter jurisdiction over this case. *See Merrell Dow Pharms. Inc. v. Thompson*, 478 U.S. 804, 810 (1986) (observing that “in exploring the outer reaches” of federal question jurisdiction, a court must make “sensitive judgments about congressional intent, judicial power, and the federal system”).

Therefore, because Agag’s claim “arises under” the NSA, Cigna’s Rule 12(b)(1) motion to dismiss is denied.

III. Motion to Dismiss Under Rule 12(b)(6)

Cigna also moves to dismiss Agag’s Complaint under Fed. R. Civ. P. 12(b)(6) for failure to state a claim. Specifically, Cigna argues that neither the FAA¹ nor the NSA provides a private right of action, and that the NSA’s text forecloses a federal court’s ability to confirm an NSA award. I address each argument in turn below.

A. Legal Standard

A motion to dismiss for failure to state a claim under Rule 12(b)(6) is designed “merely to assess the legal feasibility of a complaint, not to assay the weight of evidence which might be offered in support thereof.” *Ryder Energy Distribution Corp. v. Merrill Lynch Commodities, Inc.*, 748 F.2d 774, 779 (2d Cir. 1984) (quoting *Geisler v. Petrocelli*, 616 F.2d 636, 639 (2d Cir. 1980)).

When deciding a motion to dismiss under Rule 12(b)(6), the court must accept the material facts alleged in the complaint as true, draw all reasonable inferences in favor of the plaintiff, and decide whether it is plausible that the plaintiff has a valid claim for relief. *Ashcroft v. Iqbal*, 556 U.S. 662, 678–79 (2009); *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555–56 (2007); *Leeds v. Meltz*, 85 F.3d 51, 53 (2d Cir. 1996).

Under *Twombly*, “[f]actual allegations must be enough to raise a right to relief above the speculative level,” and assert a cause of action with enough heft to show entitlement to relief and “enough facts to state a claim to relief that is plausible on its face.” 550 U.S. at 555, 570; *see also Iqbal*, 556 U.S. at 679 (“While legal conclusions can provide the framework of a complaint,

¹ In the alternative, Cigna argues in its Rule 12(b)(6) motion that if the FAA applies, Agag is time barred from seeking confirmation of the award granted for Patient M.L. because Section 9 of the FAA “imposes a one-year statute of limitations on the filing of a motion to confirm an arbitration award[.]” Def.’s Mem. of L. in Supp. of Mot. to Dismiss Pl.’s Compl., Doc. No. 25-1, at 29-30 (quoting *Photopaint Techs., LLC v. Smartlens Corp.*, 335 F.3d 152, 158 (2d Cir. 2003)). I conclude in Section III(b) of this opinion that the FAA does not apply to the facts of this case, and therefore I reject Cigna’s statute of limitations argument. If there is any limitations period that applies to this case, it would need to be drawn from the state or federal limitations provision most analogous to the NSA. Because Cigna does not suggest any alternative limitations period, I do not resolve what that period might be.

they must be supported by factual allegations.”). The plausibility standard set forth in *Twombly* and *Iqbal* obligates the plaintiff to “provide the grounds of his entitlement to relief” through more than “labels and conclusions, and a formulaic recitation of the elements of a cause of action.” *Twombly*, 550 U.S. at 555 (quotation marks omitted). Plausibility at the pleading stage is nonetheless distinct from probability, and “a well-pleaded complaint may proceed even if it strikes a savvy judge that actual proof of [the claims] is improbable, and . . . recovery is very remote and unlikely.” *Id.* at 556 (quotation marks omitted).

B. The FAA Does Not Apply Here

Cigna argues in its Rule 12(b)(6) motion that Agag cannot seek confirmation of an NSA IDR award under the FAA. I agree that the FAA does not apply to the facts of this case. Section 9 requires that there be an “agreement” by the parties that a judgment “shall be entered upon the award made pursuant to the arbitration” 9 U.S.C. § 9. Agag concedes that, as an out-of-network provider, he does not have any contract with Cigna. Compl., Doc. No. 1, ¶ 7; *see Robinson v. Macy’s Inc.*, 772 F. Supp. 3d 253, 260 (D. Conn. 2025) (quoting *Schnabel v. Trilegiant Corp.*, 697 F.3d 110, 118 (2d Cir. 2012)) (explaining that a threshold question under Section 9 is “whether the parties have indeed agreed to arbitrate”). He also fails to provide any evidence that there is “[a] written provision” to arbitrate that would satisfy Section 9’s “agreement” requirement. *See* 9 U.S.C. § 2; *see also Mitchell F. Reiter MD PC v. Horizon Blue Cross Blue Shield of N.J.*, 2025 WL 3514300, at *3 (D.N.J. Dec. 8, 2025) (observing that “confirmation of an arbitration award under § 9 requires the existence of an ‘agreement’ or ‘contract’ where parties agree to aspects of arbitration including venue, forum, and the arbitration selection process”).

The parties only engaged in the IDR process because a statute authorized the IDR process as a dispute resolution mechanism. *See Jeffrey Farkas, M.D., LLC v. Horizon Blue Cross Blue*

Shield of N.J., 790 F. Supp. 3d 129, 136 (E.D.N.Y. 2025) (internal citation omitted) (noting that arbitration under the FAA assumes an agreement or contract to arbitrate, and the NSA's IDR is statutorily compelled). Without a written agreement to arbitrate, I cannot enter an order confirming the award pursuant to Section 9. See *Tomczak v. Raymour and Flanigan Furniture Co.*, 2014 WL 3385164, at *1 (W.D.N.Y. July 9, 2014) (emphasis in original) (quoting *Varley v. Tarrytown Associates, Inc.*, 477 F.2d 208, 210 (2d Cir. 1973)) (highlighting how Section 9 is available “only where the parties in their agreement have agreed that a judgment of the court shall be entered upon the award”).

The fact that the NSA references 9 U.S.C. § 10(a) does not change my conclusion. The NSA states that an IDR entity's determination “shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9.” 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). Paragraphs (1) through (4) of Section 10(a) list four circumstances where a federal court may vacate an arbitration award. The NSA conspicuously excludes the actual text of paragraph (a) of Section 10, which refers to arbitration awards, and only incorporates paragraphs (1) through (4), which explain reasons for vacating an award. Read in conjunction with paragraphs (1) through (4) of Section 10(a), Section 300gg-111(c)(5)(E)(i)(II) of the NSA therefore forbids judicial review of an IDR award unless: (1) “the award was procured by corruption, fraud or undue means,” (2) “there was evident partiality or corruption in the arbitrators,” (3) “the arbitrators were guilty of misconduct” or misbehavior, or (4) “the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made.” The term “arbitrators” covers IDR entities under the NSA. See *Arbitrator*, *Black's Law Dictionary* (12th ed. 2024) (defining arbitrator as “[a] neutral person who resolves disputes between parties”).

It is also relevant that Congress did not reference Section 9 anywhere in the text of the NSA. “It is a fundamental principle of statutory interpretation that ‘absent provision[s] cannot be supplied by the courts.’” *Rotkiske v. Klemm*, 589 U.S. 8, 14 (2019) (quoting Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 94 (2012)). Without proof that Congress viewed NSA IDR awards as equivalent to written agreements to arbitrate under the FAA, Section 9 cannot be applied to this case. *Med-Trans Corp. v. Capital Health Plan, Inc.*, 700 F. Supp. 3d 1076, 1084 (M.D. Fla. 2023)), *aff’d sub nom. Reach Air Med. Servs. LLC v. Kaiser Found. Health Plan, Inc.*, 160 F.4th 1110 (11th Cir. 2025) (“Neither the NSA nor the FAA says that the FAA bears on the NSA outside the four explicitly incorporated paragraphs. The Court will not assume otherwise.”).

Congress had multiple reasons not to incorporate Section 9 in the NSA. As Chief Judge Shea explained, “while IDR awards under the NSA are binding once they are issued—without further action by the parties or any court—the same is not true of arbitration awards under the FAA” *Guardian Flight v. Aetna*, 789 F. Supp. 3d at 227. Indeed, whereas arbitration awards under the FAA “must be given force and effect by being converted to judicial orders by courts,” *Key Inv. Servs., LLC v. Oliver*, 691 F. Supp. 3d 496, 502 (D. Conn. 2023) (internal citation omitted), IDR awards “are rendered in the absence of any arbitration agreement and immediately trigger the payment obligations set forth in” the NSA. *Guardian Flight v. Aetna*, 789 F. Supp. at 227. Because arbitration awards under the FAA are fundamentally different than IDR awards under the NSA, it makes sense that Congress chose purposefully to not include Section 9 of the FAA in the NSA. *See also PHI Health, LLC v. Optimum Choice, Inc.*, 2026 WL 850453, at *9 (D. Md. Mar. 27, 2026) (observing differences between arbitration awards under the FAA and IDR awards under the NSA).

Therefore, Section 9 of the FAA does not apply to the facts of this case, and Agag may not seek confirmation of an NSA IDR award under Section 9 of the FAA.

C. A Private Right of Action is Not Required to Seek Confirmation of an IDR Award

Cigna next argues that the NSA does not provide a private right of action for Agag to seek confirmation of the IDR award in federal court. District courts that have dealt with similar claims have focused almost exclusively on whether a private right of action exists under that statute, with most concluding that the NSA does not provide a private right of action. *See, e.g., East Coast Advanced Plastic Surgery, LLC v. Cigna Health & Life Ins. Co.*, 2025 WL 2371537, at *17 (S.D.N.Y. Aug. 14, 2025). But at least two district courts have concluded that the NSA does provide a private right of action. *See Guardian Flight v. Aetna*, 789 F. Supp. 3d at 227–28; *PHI Health, LLC*, 2026 WL 850453, at *7.

That focus on the private right of action question is misplaced. A private right of action is only required when a party seeks to enforce *substantive* rights in federal court, or at least when the party seeks a determination of the merits of a particular claim. *See Private Right of Action*, *Black’s Law Dictionary* (12th ed. 2024) (emphasis added) (defining “private right of action” as “[a]n individual’s right to *sue* in a personal capacity to enforce a legal claim”). Here, Agag’s motion to confirm asks me to act in a purely ministerial way and enter as a judgment an earlier binding determination that Cigna is obligated to pay Agag a specific sum of money for services covered under the NSA.

Although Section 9 of the FAA does not apply to the facts of this case, Agag’s request is analogous to how confirmation proceedings are handled under the FAA. The Second Circuit has explained that confirmation of an arbitration award under the FAA is “a summary proceeding that merely makes what is already a final arbitration award a judgment of the court . . .” *D.H.*

Blair & Co., Inc. v. Gottdiener, 462 F.3d 95, 110 (2d Cir. 2006) (internal citation omitted).

Accordingly, a court does not evaluate the merits of the arbitration award unless an enumerated exception applies. *See Manor House Cap., LLC v. Pritsker*, 2015 WL 273684, at *2 (S.D.N.Y. Jan. 15, 2015) (internal citation omitted). In that way, a district court’s role is sharply circumscribed. *Hall Street Assocs., L.L.C. v. Mattel, Inc.*, 552 U.S. 576, 587 (2008) (cleaned up) (“There is nothing malleable about ‘must grant,’ which unequivocally tells courts to grant confirmation in all cases, except when one of the ‘prescribed’ exceptions applies.”). I discuss the parallels between the structure of the FAA and the NSA in more detail later in this opinion, but I note here the similarities between Agag’s motion and FAA confirmation hearings to highlight how courts may engage in summary enforcement proceedings regardless of whether a private right of action exists.

Ultimately, Agag’s Motion to Confirm is similar to a request a party might make under Section 9 of the FAA. He does not ask me to consider the merits of the IDR award or to recognize any substantive right under the NSA. All he asks me to do is to confirm earlier judgments by IDR entities that themselves considered the merits of both parties’ claims.² The traditional right-of-action analysis therefore does not apply here, and the cases cited by Cigna are not on point because they all deal with plaintiffs asserting new substantive rights. *See, e.g.*,

² Although 28 U.S.C. § 1963 does not apply here by its terms, I see parallels between a request to register a foreign judgment under 28 U.S.C. § 1963 and a request to confirm an IDR award under the NSA. Even if not perfectly analogous, the two proceedings are similar in that neither involves the recognition of a new substantive right or an adjudication of the merits of a claim. When a federal court registers a foreign judgment under 28 U.S.C. § 1963, it does not look to whether a right of action exists. *See G&A Strategic Invs. I LLC v. Petroleos de Venezuela, S.A.*, 810 F. Supp. 3d 463, 467 (S.D.N.Y. 2025) (“Once registered in another district, it is as if the judgment was entered by a district court of that district . . .”). Instead, a court merely ensures that it has subject matter jurisdiction before registering that foreign judgment. *See CSX Transp., Inc. v. Filco Carting Corp.*, 2011 WL 2713487, at *2 (E.D.N.Y. July 11, 2011) (explaining that 28 U.S.C. § 1963 applies once “the party seeking to enforce a registered judgment against a third party can establish federal jurisdiction”). Just as registration of a foreign judgment leaves untouched an earlier assessment of the merits by a separate district court, Agag’s request to confirm the IDR award does not ask me to evaluate the merits of the dispute between Agag and Cigna—*i.e.*, how much Cigna should pay Agag. The merits of that dispute, like that of a separate district court judgment in the Section 1963 context, were already evaluated by the IDR entities that ruled in Agag’s favor.

Alexander v. Sandoval, 532 U.S. 275, 279 (2001) (evaluating whether private plaintiffs could make disparate impact claims under Title VI of the Civil Rights Act of 1964); *Republic of Iraq v. ABB AG*, 768 F.3d 145, 169-171 (2d Cir. 2014) (discussing whether a private right of action exists to sue under the Foreign Corrupt Practices Act).

D. The NSA’s Bar on Judicial Review Does Not Preclude Confirmation of the IDR Award

Cigna also argues that the text of Section 300gg-111(c)(5)(E)(i)(II) of the NSA forecloses a federal court’s ability to take up this case. That provision states that IDR awards “shall not be subject to judicial review, except in a case described in any of paragraphs (1) through (4) of section 10(a) of title 9.” 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). I concluded earlier that Section 300gg-111(c)(5)(E)(i)(II) forbids a court from engaging in judicial review of an IDR award unless one of the circumstances enumerated in paragraphs (1) through (4) of 9 U.S.C. § 10(a) is present during the IDR process.

A central question then is what constitutes “judicial review.” Cigna proposes a broad definition of “judicial review” and argues that the statute only permits a federal court to hear “complex, fact-determinative actions to *vacate* IDR awards,” and not actions to *enforce* IDR awards. Def.’s Mem. of L. in Supp. of Mot. to Dismiss Pl.’s Compl., Doc. No. 25-1, at 26-27 (emphasis added). The Fifth Circuit—the only appellate court so far to rule on the issue—endorsed a similar reading. *See Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th at 275.

I conclude that merely confirming an IDR award does not constitute judicial review. The Fifth Circuit notes that the term “is broad enough to include a court’s order to enforce an IDR award” because “[r]eview’ includes ‘[p]lenary power to *direct and instruct an agent or subordinate*, including the right to remand, modify, or vacate any action by the agent or

subordinate, or to act directly in place of the agent or subordinate.” *Id.* (emphasis in original) (quoting *Review*, *Black’s Law Dictionary* (12th ed. 2024)). The Fifth Circuit does not identify who the “agent or subordinate” being directed or instructed might be in a proceeding that merely confirms an IDR award. I also question why the Fifth Circuit looked to the dictionary definition of the term “review” when Congress specifically used the term “*judicial* review.” That focus on “review” rather than “judicial review” violates the surplusage canon, which “reflect[s] an assumption applicable to ‘all sensible writing: Whenever a reading arbitrarily ignores linguistic components . . . the reading may be presumed improbable.’” *Feliciano v. Dep’t of Trans.*, 605 U.S. 38, 51-52 (2025) (quoting Scalia & Garner, *Reading Law* 174).

A better approach would look at the dictionary definition of the phrase that Congress used in the NSA. *See* Scalia & Garner, *Reading Law* 101 (explaining under the general-terms canon that “general words . . . are to be accorded their full and fair scope. They are not to be arbitrarily limited.”). That phrase—“judicial review”—can be defined in at least three ways:

1. A court’s power to review the actions of other branches or levels of government; esp., the courts’ power to invalidate legislative and executive actions as being unconstitutional.
2. The constitutional doctrine providing for this power.
3. A court’s review of a lower court’s or an administrative body’s factual or legal findings.

Judicial Review, *Black’s Law Dictionary* (12th ed. 2024). Confirming an IDR award does not implicate any of these definitions of judicial review. No action has been taken by another branch of government. No constitutional doctrine is involved. And confirmation does not constitute review of a court or administrative body’s factual or legal findings.

The Fifth Circuit cites to an ERISA case to show that the Supreme Court has used the term “judicial review” to encompass “actions that seek to confirm or enforce a dispute resolution award.” *Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th at 275-76 (citing *Concrete Pipe & Prods. of Cal., Inc. v. Constr. Laborers Pension Trust*, 508 U.S. 602, 611

(1993)). But a single ERISA case that the drafters of the NSA may not have even considered does not establish how Congress defined “judicial review” in the NSA.

Instead, to understand what Congress meant in the NSA when it limited judicial review to the four circumstances laid out in Section 10(a) of the FAA, it is more helpful to look at the statute that we know Congress considered when it drafted the NSA—the FAA. Case law is clear regarding a federal court’s role in a confirmation proceeding under the FAA: a court “‘*must* grant’ the [arbitration] award ‘unless the award is vacated, modified, or corrected.’” *D.H. Blair & Co., Inc.*, 462 F.3d at 110 (emphasis added) (quoting 9 U.S.C. § 9). And “a court may change or vacate an arbitration award *only* where” a list of circumstances enumerated in Sections 10 and 11 of the FAA exist. *Tomczak*, 2014 WL 3385164, at *3 (emphasis in original) (discussing Section 9 of the FAA).

There is a clear parallel structure between the FAA and the NSA. Recall that Section 300gg-111(c)(5)(E)(i) of the NSA states that the IDR award “shall be binding upon the parties involved” and “shall not be subject to judicial review” unless one of four grounds for vacating the award is present. “Binding” means that the award has “legal force” and “require[s] obedience.” *See Binding, Black’s Law Dictionary* (12th ed. 2024). With that definition in mind, Section 300gg-111(c)(5)(E)(i) of the NSA essentially says that an IDR award must have legal force and that a court may only conduct judicial review, *i.e.*, consider its merits, when the award is subject to a motion to vacate. *See Scalia & Garner, Reading Law* 114 (explaining that, under the mandatory/permissive canon, “when the word *shall* can reasonably be read as mandatory, it ought to be so read”). The NSA, furthermore, lays out that an award may only be vacated when paragraphs (1) through (4) of Section 10 of the FAA apply. If an IDR award requires obedience and may only be vacated if paragraphs (1) through (4) of 9 U.S.C. § 10(a) applies, it is almost

identical to the framework laid out in the FAA. A court therefore must confirm the award unless a party moves to vacate it under paragraphs (1) through (4) of 9 U.S.C. § 10(a). *See D.H. Blair & Co. Inc.*, 462 F.3d at 110.

The parallel structure between the FAA and the NSA is also helpful because Congress knew about the FAA when it constructed the NSA, and under the FAA, a court does not engage in judicial review when it confirms an award. During a confirmation proceeding under the FAA, the decision whether to confirm an arbitral award “is not intended to involve complex factual determinations, other than a determination of the limited statutory conditions for confirmation or grounds for refusal to confirm.” *Zeiler v. Deutsch*, 500 F.3d 157, 169 (2d Cir. 2007). Because confirmation of an arbitral award is not intended to involve complex factual determinations, a court does not review “an administrative body’s factual or legal findings” when it confirms that award. *Judicial Review*, *Black’s Law Dictionary* (12th ed. 2024); *see also Tomczak*, 2014 WL 3385164, at *3 (quoting *Willemijn Houdstermaatschappij, BV v. Standards Microsystems Corp.*, 103 F.3d 9, 12 (2d Cir.1997)) (noting that a court’s “review” of an arbitration award is “severely limited”). To reiterate, “[a] petition brought under the FAA is not an occasion for *de novo* review of an arbitral award, nor an occasion for the court to conduct a reassessment of the evidentiary record.” *Eletson Holdings, Inc. v. Levona Holdings Ltd.*, 731 F. Supp. 3d 531, 566 (S.D.N.Y. 2024) (cleaned up). Rather, in a confirmation proceeding, a court must enter judgment for the party seeking confirmation unless there is a motion to vacate under the FAA. *See Trustees Of the UNITE HERE Nat’l Health Fund v. JY Apparels, Inc.*, 535 F. Supp. 2d 426, 429 (S.D.N.Y. 2008).

Because I am not examining the merits of the IDR entity’s determination or assessing which of the offers provided by Agag and Cigna should have been selected, I am acting just as I

would in a FAA confirmation proceeding. In that context, as is the case here, I am not reviewing “an administrative body’s factual or legal findings.” I am therefore not engaged in judicial review, and the statute does not bar confirmation of the IDR awards at issue today. *See also PHI Health, LLC*, 2026 WL 850453, at *9 (concluding, based in part on how the Administrative Procedure Act views “judicial review,” that “judicial review” means “to challenge” a decision, not to enforce or confirm a determination); *Reach Air Medical Servs. LLC v. Kaiser Found. Health Plan Inc.*, 160 F.4th 1110, 1115 (11th Cir. 2025) (suggesting that, in FAA and NSA cases, a court only engages in judicial review when it considers whether to vacate an award).

E. The NSA’s Administrative Framework Does Not Prohibit Judicial Confirmation

Finally, Cigna argues that even if the award is “binding” upon the parties, that language does not mean that a federal court can confirm it and thereby permit enforcement of the award. That is because, according to Cigna, the NSA lays out a comprehensive administrative scheme that allows providers like Agag to enforce the IDR award, and “[t]he existence of a detailed administrative remedy is strong evidence that Congress intended it to be the exclusive remedy.” Def.’s Mem. of L. in Supp. of Mot. to Dismiss Pl.’s Compl., Doc. No. 25-1, at 20-21 (citing *N.Y. Inst. of Dietetics v. Great Lakes Higher Educ. Corp.*, 1995 WL 562189, at *4 (S.D.N.Y. Sept. 21, 1995)). The Fifth Circuit adopted that view, as have district courts across the country. *Guardian Flight, L.L.C. v. Health Care Serv. Corp.*, 140 F.4th at 277; *East Coast Advanced Plastic Surgery, LLC*, 2025 WL 2371537, at *17; *Mitchell F. Reiter MD PC*, 2025 WL 3514300, at *4; *Worldwide Aircraft Servs. Inc. v. Freedom Life Ins. Co. of Am.*, 2025 WL 3551397, at *2 (M.D. Fla. Dec. 11, 2025); *Axis Neuromonitoring, LLC*, 2026 WL 795260, at *6-7.

The NSA simply does not set out a “detailed administrative remedy” for enforcing IDR awards. Although the NSA authorizes HHS to impose civil monetary penalties on health

insurance plans that do not pay the IDR award within 30 days, those penalties are paid to the United States government, not to the provider. *See* 42 U.S.C. § 300gg-22(b)(2)(C); *see also PHI Health, LLC*, 2026 WL 850453, at *10 (commenting that the prescribed monetary penalties are only “payable to the government” and not providers). Furthermore, even if health insurance companies that face civil monetary penalties are offered an opportunity to challenge the civil monetary penalty before an administrative law judge, that hearing focuses on the legitimacy of the civil monetary penalty, not the IDR award itself. *See* 42 U.S.C. § 300gg-22(b)(2)(D). Under the current system, moreover, a provider does not have *any* right to be heard before an administrative law judge when an IDR award remains unpaid.

Although the statute provides that the Attorney General “shall recover the amount assessed by action in the appropriate United States district court,” that federal court action is designed only to recover the civil monetary penalty owed by the health insurance company to the HHS. *Id.* § 300gg-22(b)(2)(F)(i). The procedure does not compel the health insurance company to pay the IDR award to the provider. *See PHI Health, LLC*, 2026 WL 850453, at *10 (“Nothing in the No Surprises Act authorizes HHS (or DOL or Treasury or any state agency for that matter) to order a payor that is in violation of the Act to comply with an IDR determination.”). Indeed, it is conceivable that a health insurance company could choose to pay the civil monetary penalty but not the IDR award, because a civil monetary penalty under the NSA is \$100 per day, 42 U.S.C. § 300gg-22(b)(2)(C), whereas an IDR award, like in the case of Patient M.L. here, can be many times that amount. *See* Compl., Doc. No. 1, ¶ 19 (stating that the IDR award for Patient M.L. is \$97,500.00). Once a civil monetary penalty is paid, any case against a non-paying health insurance company theoretically closes until the provider refiles a complaint. When there is a significant disparity between a civil monetary penalty and an IDR award—*e.g.*, \$100 per day vs.

\$97,500—a health insurance company has significant incentive to choose paying the former amount many times over (974 times in Patient M.L.’s case) instead of ever paying the provider. A health insurance company can therefore effectively ignore the IDR award under the NSA’s administrative framework.

Cigna also highlights the considerable rulemaking authority vested in the HHS to oversee the NSA. For instance, it points out how the NSA authorizes the HHS to create an audit process to ensure that health insurance companies “are in compliance with the requirement of applying a qualifying payment amount” under the NSA. 42 U.S.C. § 300gg-111(a)(2)(A)(i)(I). That audit process, however, does not investigate whether IDR awards are being paid to out-of-network providers. *See Guardian Flight v. Aetna*, 789 F. Supp. 3d at 229 (“Nothing in § 300gg-111 suggests that these audits would evaluate health plans’ and insurers’ compliance with the NSA’s Timing of Payment provision . . .”). Although the NSA requires the HHS to establish a process by which providers may submit complaints—and CMS has set up a “No Surprises Help Desk” to accept provider complaints—it is not clear what steps, if any, CMS takes to resolve a complaint. CMS plausibly could do anything from imposing a civil monetary penalty—which I already concluded is by itself not an adequate remedy—to threatening a health insurance company with stricter enforcement actions. But without knowing the administrative process addressing payment of the IDR award to a provider, I cannot conclude that the NSA provides for an administrative remedy that is so comprehensive that a federal court is barred from confirming an IDR award. *See PHI Health, LLC*, 2026 WL 850453, at *10 (“[T]he limited availability of civil monetary penalties under the No Surprises Act is not an ‘enforcement scheme,’ let alone one that is ‘comprehensive.’”).

To reiterate, an administrative ‘remedy’ that does not lead to the provider being paid is not a remedy at all. I reject a construction of the statute that bars judicial confirmation of an IDR award simply because there exists some semblance of an administrative scheme that does not ensure that the provider will be paid without the need to go to federal court. *See United States v. Castleman*, 572 U.S. 157, 178 (2014) (Scalia, J., concurring in part and dissenting in part) (defining the “presumption against ineffectiveness” canon as “the idea that Congress presumably does not enact useless laws”).

F. The NSA Does Not Provide a Private Right of Action for a Provider to Seek Damages

In addition to confirmation of the five IDR awards at issue, Agag requests an order directing Cigna to pay \$142,567.99 in damages, as well as attorney’s fees, interests, and costs. Compl., Doc. No. 1, at 11. For Agag to obtain damages as opposed to confirmation of the IDR award, he needs to show that the NSA created a private right of action for providers to sue in federal court. *See Private Right of Action, Black’s Law Dictionary* (12th ed. 2024) (defining “private right of action” as “[a]n individual’s right to sue in a personal capacity to enforce a legal claim”). That is because, unlike his request for confirmation, his claim for damages seeks to enforce substantive rights under the NSA.

To determine if a statute provides a private right of action, a court begins “with the text and structure of” the statute. *Sandoval*, 532 U.S. at 288. Agag does not point to any section of the NSA that expressly allows for a provider to seek damages in federal court. That is because the NSA “contains no explicit provisions” to that effect. *See Republic of Iraq*, 768 F.3d at 170. There is therefore not an express private right of action that would allow providers like Agag to sue for damages under the NSA.

Even when there is not an express private right of action, a private right of action may exist impliedly if the statute displays “an intent to create not just a private right but also a private remedy.” *Id.* (internal citation omitted); *but see Olmsted v. Pruco Life Ins. Co. of N.J.*, 283 F.3d 429, 432 (2d Cir. 2002) (cautioning that a court “cannot ordinarily conclude that Congress intended to create a right of action when none was explicitly provided”). On the private remedy requirement, “[t]he express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others.” *Sandoval*, 532 U.S. at 290. I concluded earlier that the text of Section 300gg-111(c)(5)(E)(i) authorizes a provider to seek confirmation of an IDR award in federal court. For that reason, and because Agag provides no evidence that Congress intended to create a remedy other than confirmation, I conclude that the NSA does not create an implied private right of action that allows a provider to sue for damages under the statute.

Therefore, Cigna’s Rule 12(b)(6) motion to dismiss is GRANTED with regard to Agag’s request to confirm the IDR awards under Section 9 of the FAA and his request for damages under the NSA, but DENIED otherwise. Agag may seek confirmation of the IDR awards under Section 300gg-111(c)(5)(E)(i) of the NSA.

IV. Agag’s Cross-Motion to Confirm

Agag moves for an order confirming the five IDR awards at issue in this case. *See* Doc. No. 33. Although those IDR awards are already “binding” under the NSA—meaning that Cigna has an obligation to pay those amounts to Agag—Agag has no way to compel payment of those awards without obtaining a court judgment. Confirmation of an IDR award therefore matters for much the same reason as it does in the FAA context. “Armed with a court order the winning party has a variety of remedies available to enforce the judgment.” *Florasynth Inc. v. Pickholz*, 750 F.2d 171, 176 (2d Cir. 1984).

Cigna argues that Agag's Cross-Motion to Confirm should be denied because the NSA only covers "disputes over the amount of payment for certain covered services," and "Cigna's denials relate to coverage, not reimbursement." Def.'s Reply Mem. of L. in Further Supp. of Mot. to Dismiss Pl.'s Compl. and in Opp'n to Pl.'s Cross-Mots. to Confirm and for Summ. J., Doc. No. 36, at 17, 19. Put more simply, Cigna suggests that I should not confirm the five IDR awards at issue because "the services provided [by Agag] are not benefits covered under the terms of [the two patients'] health plan[s]." *Id.* at 19.

Cigna is asking me to review the IDR entities' factual and legal findings and therefore to engage in judicial review. Cigna does so even though it had earlier argued that I may not confirm an IDR award because doing so would entail judicial review. The NSA prohibits judicial review with limited exceptions. Cigna essentially argues that I may not engage in judicial review when doing so is to its detriment (*i.e.*, confirming an unpaid IDR award) but that I should engage in judicial review when doing so is to its advantage (*i.e.*, not confirming an unpaid IDR award).

Judicial review of an NSA IDR award is *only* permissible when a party moves to vacate an award under the grounds outlined in paragraphs (1) through (4) of Section 10(a) of the FAA. 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). I already concluded that I do not engage in judicial review by merely confirming an IDR award. If Cigna wants to challenge the merits of an IDR award, then it needs to move to vacate the award under Section 300gg-111(c)(5)(E)(i)(II). But Cigna has not moved to vacate the awards at issue here.³

³ It may well be too late for Cigna to move to vacate these IDR awards. Although I do not decide the statute of limitations, I note that the most clearly analogous statute of limitations to file a motion to vacate an arbitration award is three months from its entry. See 9 U.S.C. § 12 ("Notice of a motion to vacate, modify, or correct an award must be served upon the adverse party or his attorney within three months after the award is filed or delivered.").

In the absence of a motion to vacate, I may only deny a motion to confirm if there is evidence of “a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved.” *Id.* § 300gg-111(c)(5)(E)(i)(I). Because Cigna does not provide evidence that Agag engaged in fraud or misrepresentation, Agag’s Cross-Motion to Confirm is GRANTED. *See Reach Air Medical Servs. LLC*, 160 F.4th at 1115 (observing the “strong legal presumption that arbitration awards will be confirmed under the FAA,” which carries over to “the newly codified NSA, which has expressly incorporated some sections of the [FAA]”).

V. Conclusion

For the foregoing reasons, Cigna’s Motion to Dismiss, Doc. No. 25, is **GRANTED** with regard to Agag’s request to confirm the IDR awards under Section 9 of the FAA and his request for damages under the NSA, but **DENIED** otherwise. Agag’s Cross-Motion to Confirm, Doc. No. 33, is **GRANTED**.

The Clerk is directed to enter judgment confirming the IDR awards in the amount of \$142,567.99 for Agag and against Cigna. Post-judgment interest shall accrue from the date of the entry of the judgment. The Clerk shall close this case.

SO ORDERED at Bridgeport, Connecticut this 15th day of April 2026.

/s/ STEFAN R. UNDERHILL
Stefan R. Underhill
United States District Judge

JA-432

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**UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT**

RICHARD AGAG,

Plaintiff,

v.

3:25-cv-00498-SRU

CIGNA HEALTH AND LIFE
INSURANCE COMPANY,

Defendant.

JUDGMENT

This action came on for consideration on defendant's motion to dismiss and plaintiff's cross-motion to confirm before the Honorable Stefan R. Underhill, United States District Judge. The Court, having reviewed all papers filed in conjunction with the motions, entered an order on April 15, 2026, granting the plaintiff's cross-motion to confirm, granting the defendant's motion with respect to Agag's request to confirm the IDR awards under Section 9 of the FAA and his request for damages under the NSA, and otherwise denying the defendant's motion to dismiss, for the reasons stated in the ruling. It is therefore;

ORDERED, ADJUDGED, and DECREED that judgment shall enter confirming the IDR awards in the amount of \$142,567.99 for the plaintiff, RICHARD AGAG, and against defendant CIGNA HEALTH AND LIFE INSURANCE COMPANY. As stated in the ruling, post-judgment interest shall accrue from the date of the entry of this judgment and this case is closed.

Dated at Bridgeport, Connecticut, this 16th day of April 2026.

DINAH MILTON KINNEY, Clerk

By: /s/ Julia Reis
Deputy Clerk

EOD: 4/16/2026

JA-433

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United States District Court for the District of Connecticut

Case Number: 3:25-cv-00498-SRU

RICHARD AGAG, MD,

List the full name(s) of the plaintiff(s)/petitioner(s)

v.

NOTICE OF APPEAL

CIGNA HEALTH AND LIFE INSURANCE
COMPANY,

List the full name(s) of the defendant(s)/respondent(s)

Notice is hereby given that CIGNA HEALTH AND LIFE INSURANCE COMPANY in the above-
*List the names of all parties who are filing an appeal

named case, hereby appeal to the United States Court of Appeals for the Second Circuit from the

☒ final judgment entered in this action on 04/16/2026
Date Entered

OR

☐ order #() entered in this action on described as:
Date Entered

(Provide a brief description of the decision in the order/judgment)

May 1, 2026

s/ Caroline E. Oks

Date

Signature

Oks, Caroline, E; FBT Gibbons LLP (Counsel to Defendant Cigna Health and Life Insurance Company)

Name (Last, First, MI)

One Gateway Center, Newark, New Jersey 07102

Address

City

State

(973) 596-4500

coks@fbtgibbons.com

Telephone

E-mail Address (if available)

*See Rule 3(c) for permissible ways of identifying appellants. Attach additional pages as necessary.

Note to inmate filers: If you are an inmate confined in an institution and you seek the timing benefit of Fed. R. App. P. 4 (c)(1), complete Form 7 (declaration of Inmate Filing) and file that declaration along with this Notice of Appeal.