BorgWarner Inc.

MEDICAL BENEFITS ABROAD®

EFFECTIVE DATE: January 1, 2021

CN002
04612A

This document printed in January, 2021 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

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

CIGNA HEALTH AND LIFE INSURANCE COMPANY

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

POLICYHOLDER: Wilmington Trust National Association

GROUP: BorgWarner Inc.

GROUP POLICY(S) — COVERAGE
04612A - MEDICAL BENEFITS ABROAD®

EFFECTIVE DATE: January 1, 2021

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

Anna Krishtul
Anna Krishtul, Corporate Secretary

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

Additional Programs, Services and Resources

In addition to the insurance benefits described in this policy, we may provide or arrange for others to provide additional programs, services, and resources that are intended to promote the well-being and sense of security of our members in the event they may require emergency care services while traveling outside their home country. Contact us for details regarding any such additional programs and services.

HC-SPP52 11-17

How To File Your Claim

For Emergency Medical Illness and Injury

Proof of Loss

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

Timely Filing of Claims - for Emergency Medical Illness and Injury

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365) days after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within one year (365) days, 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-CLM130 01-20

Eligibility - Effective Date

Member Insurance

This plan is offered to you as a Member.

Eligibility for Member Insurance

You are eligible for insurance if:

- you are in a Class of Eligible Members as determined by the Group and covered under the Group's health plan or other comprehensive health coverage in your country of residence or permanent assignment if outside the United States;
- you are traveling outside your country of residence or permanent assignment for no more than 180 consecutive days per trip on the business of, or at the expense of, the Group or on Sojourn Travel; and
- you pay any required contribution.

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 if that Dependent is traveling with you outside their country of residence or permanent assignment for no more than 180 consecutive days per one trip on the business of, or at the expense of, the Group or on Sojourn Travel.

Any person for whom coverage is prohibited under applicable law will not be considered eligible.

Classes of Eligible Members

Each Member as reported to the insurance company by the Group.

Effective Date of Member Insurance

Your coverage will be effective when you meet the Eligibility requirements for Member Insurance above.

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 when you become eligible for Member Insurance and your Dependent(s) become eligible for Dependent Insurance.

All of your Dependents as defined will be included.
Your Dependents will be insured only if you are insured.

HC-ELG279 01-20

Medical Benefits Abroad®

The Schedule

Emergency Medical Illness and Injury Benefits

For You and Your Dependents

To receive Emergency Medical Illness and Injury Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible and Coinsurance, if any.

This Plan provides coverage only for the following Emergency Services and Urgent Care while traveling. See definitions of Emergency Services and Urgent Care.

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.

Deductibles

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

Out-of-Pocket Expenses

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

- 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.
- Provider charges in excess of the Maximum Reimbursable Charge.

Multiple Surgical Reduction – applies in the United States only

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 – applies in the United States only

Assistant Surgeon

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

Co-Surgeon

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

BENEFIT HIGHLIGHTS	
Calendar Year Emergency Medical Illness and Injury Benefit Maximum	$100,000

BENEFIT HIGHLIGHTS	
The Percentage of Covered Expenses the Plan Pays	100% of the Maximum Reimbursable Charge (see below)
Maximum Reimbursable Charge **Services in the United States** Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A percentage of a fee schedule that Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar 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 the 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 and Coinsurance.	300%
Maximum Reimbursable Charge **Services Outside the United States** Maximum Reimbursable Charge for services outside the United States is determined based on the lesser of: • the charges contracted or otherwise agreed between the provider and Cigna; or • the charge that a provider most often charges patients for the service or procedure; or • the customary charge for the service or procedure as determined by Cigna based upon the range of charges made for the service or procedure by most providers in the general geographic area where the service is rendered or the procedure performed. Cigna is not obligated to pay excessive charges. **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 and Coinsurance.	100%

BENEFIT HIGHLIGHTS	
Calendar Year Deductible **Individual** **Family Maximum Calculation** **Individual Calculation:** Family members meet only their individual Deductible and then their claims will be covered under the plan Coinsurance.	$0 per person
Out-of-Pocket Maximum **Individual** **Family Maximum Calculation** **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%.	$0 per person
Physician's Services Physician's Office Visit Surgery Performed in the Physician's Office	 The plan pays 100% The plan pays 100%
Inpatient Hospital - Facility Services Semi-Private Room and Board Private Room Special Care Units (ICU/CCU)	The plan pays 100% Limited to the semi-private room rate Private room covered outside the United States only if no semi-private room equivalent is available. Limited to the ICU/CCU daily room rate per day.
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room	The plan pays 100%
Inpatient Hospital Physician's Visits/Consultations	The plan pays 100%
Inpatient Professional Services Surgeon, Radiologist, Pathologist, Anesthesiologist	The plan pays 100%
Outpatient Professional Services Surgeon, Radiologist, Pathologist, Anesthesiologist	The plan pays 100%
Ambulance	The plan pays 100%
Laboratory and Radiology Services **Advanced Radiology Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)** Physician's Office Visit Outpatient Hospital Facility Independent Lab Facility	The plan pays 100%

BENEFIT HIGHLIGHTS	
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: Unlimited Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Chiropractic Therapy (includes Chiropractors)	The plan pays 100%
Medical Pharmaceutical Products Coverage also includes replacement of lost medical pharmaceutical products	The plan pays 100%
Emergency Dental Care Treatment of accidental injury to sound, natural teeth Calendar Year Maximum: $1,000 Physician's Office Visit Inpatient Facility Outpatient Facility Inpatient Professional Services Outpatient Professional Services	The plan pays 100%
War Risk Benefit	Not Covered
Sojourn Travel Benefit Maximum: 7 days, when taken in conjunction with an approved business trip	The plan pays 100%
Emergency Medical Evacuation & Repatriation Benefit Maximum: $100,000	
Emergency Medical Evacuation	The plan pays 100%
Repatriation Following a Medical Evacuation	The plan pays 100%
Repatriation of Mortal Remains	The plan pays 100%
Primary Repatriation to the Permanent Residence after a Serious Medical Event	The plan pays 100%
Emergency Family Travel Arrangements and Confinement Visitation	The plan pays 100%
Return of Dependent Children	The plan pays 100%

Certification Requirements -Emergency Medical Illness and Injury Benefits

Required for all United States Hospital Stays

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.

In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. 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 $300 of Hospital charges made for each separate admission to the Hospital unless PAC is received within 48 hours after the emergency admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will be reduced by 50%:

- 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.

HC-PAC100 01-20

Covered Expenses

Emergency Medical Illness and Injury Benefits

The term Covered Expenses means expenses incurred by a person while covered under this plan 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 made for Emergency Services or Urgent Care for the care and treatment of an Injury or a Sickness, as determined by Cigna.
- for services or supplies that are Medically Necessary for Emergency Services or Urgent Care or for the care of treatment of an Injury or Sickness, as determined by Cigna and that are not otherwise excluded from coverage by terms of this policy.

As determined by Cigna, Covered Expenses may also include all charges made by and 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 Coinsurance, 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 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 laboratory services and other diagnostic and therapeutic radiological procedures.
- any care furnished to a newborn child including Hospital nursery expenses prior to discharge from the Hospital.
- medical expenses related to non-routine maternity care.
- charges made for a Dental Emergency up to the benefit amount listed in The Schedule. If treatment requires an immediate need for restoration coverage for fillings and or root canal to prevent further dental pain, these charges would be covered up to the amount shown in The Schedule.

Internal and External Prosthetic/Medical Appliances

Charges made for internal and external prosthetic/medical appliances that provide permanent or temporary internal and external functional supports for nonfunctional body parts are covered. Repair, maintenance or replacement of a covered appliance is also covered in the event of an emergency.

Short-Term Rehabilitative Therapy and Chiropractic Care Services

Following a covered acute medical emergency, charges for Medically Necessary short term rehabilitation services including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, are covered when provided in the most medically appropriate setting. Also included, following a covered acute medical emergency, are charges made for Medically Necessary diagnostic and treatment services utilized in an office setting by a chiropractic Physician. 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.

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:

- treatment for chronic, ongoing, or continuation of a Sickness, Injury or medical condition, or treatment of a Sickness, Injury, or medical condition which began prior to traveling;
- 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, or verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- 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 visit.

Medical Pharmaceutical Products

Charges made for medical pharmaceutical products.

Coverage will be provided for medical pharmaceutical products for necessary medications that were lost while traveling.

Emergency Medical Evacuation and Repatriation Benefits

Covered Expenses

Expenses incurred for evacuation or repatriation without the approval and authorization of Cigna, and/or its designee will not be Covered Expenses. Only those expenses approved by Cigna will be eligible for coverage and/or reimbursement under the terms of your plan.

If you or your Dependent suffer a medical emergency and, Cigna, and/or its designee, determines that appropriate medical facilities are not available locally, Cigna may arrange for an evacuation to the nearest appropriate facility.

You or your Dependent must contact Cigna at the phone number indicated on your ID card to begin this process. In making their determinations, Cigna, and/or its designee, will consider the nature of the emergency, your condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to the specific Medical Necessity of each case.

Repatriation Following a Medical Evacuation

Covered Expenses

Following any covered emergency medical evacuation, Cigna will pay for one of the following:

- if it is deemed Medically Necessary and appropriate by the Cigna medical director, you or your Dependent will be transferred to your permanent residence via a one-way economy airfare; or
- you or your Dependent will be transferred back to your original work location or the location from which you were evacuated via a one-way economy airfare.

If your transportation needs to be medically supervised a qualified medical attendant will escort you. Additionally, if Cigna, and/or its designee, determines a mode of transport other than economy class seating on a commercial aircraft is required for Medical Necessity reasons, Cigna, or its designee, will arrange accordingly and such will be covered by Cigna.

Primary Repatriation to the Permanent Residence after a Serious Medical Event

Following a serious medical event, if it is deemed Medically Necessary and appropriate by the Cigna medical director,

Cigna may pay for you or your Dependent to be transferred to your permanent residence via a one-way economy airfare.

If the Cigna medical director determines that transportation needs to be medically supervised a qualified medical attendant will escort you. Additionally, if Cigna determines a mode of transport other than economy class seating on a commercial aircraft is required for Medical Necessity reasons, Cigna, or its designee, will arrange accordingly and such will be covered by Cigna.

Repatriation of Mortal Remains

The costs associated with the transportation of mortal remains from the place of death to the home country will be covered. In addition, assistance will be provided by Cigna, or its designee, for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

Emergency Family Travel Arrangements and Confinement Visitation

If Cigna determines that you or your Dependent is expected to require hospitalization in excess of 7 days at the location to which you will be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by you. If a Dependent child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent child is hospitalized. Only those expenses approved by Cigna and/or its designee prior to occurrence will be eligible for coverage and reimbursement under the terms of your plan.

Return of Dependent Children

If Dependent child(ren) are left unattended by virtue of the evacuee's absence following a covered evacuation, a one-way economy airfare will be provided to their place of residence or that of an individual chosen by you.

Exclusions

No payment will be made for charges for:

- services rendered without the authorization or intervention of Cigna, or its designee.
- non-emergency routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to you.
- a condition which would allow for treatment at a future date convenient to you and which does not require emergency medical evacuation or repatriation.
- medical care or services scheduled for member or providers convenience which are not considered an emergency.
- expenses incurred if the original or ancillary purpose of your trip is to obtain medical treatment.
- services provided for which no charge is normally made.
- expenses incurred while serving in the armed forces of another country.
- transportation for your vehicle and/or other personal belongings involving intercontinental and/or marine transportation.
- service provided other than those indicated in this certificate.
- housing/lodging or accommodations, meals or travel related expenses.
- hotel and accommodations for covered Dependents post discharge or while awaiting fitness to fly approval.
- Expenses incurred in the United States are excluded.
- for claim payments that are illegal under applicable law.

HC-COV878 01-20

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:

- Injury or Sickness which results from or in the course of an insured's regular occupation for wage or profit. (This does not apply to a corporate officer, partner or sole proprietor who is not insured under Workers' Compensation Employer's Liability Law or similar law).
- expenses incurred for flight in, boarding or alighting from an aircraft or any craft designed to fly above the Earth's surface:
  - except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
  - being flown by the covered person or in which the covered person is a member of the crew;
  - being used for:
    - crop dusting, spraying or seeding, giving and receiving flying instruction, fire-fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
    - any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
    - designed for flight above or beyond the earth's atmosphere;
    - an ultra-light or glider;
    - being used by any military authority, except an aircraft used by the Air Mobility Command or its foreign equivalent; or

  - being used for the purpose of parachuting or skydiving.
- Injury or Sickness for which you are entitled to benefits under Workers' Compensation Law, Employer's Liability Law or similar law.
- expenses incurred for travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle.
- expenses incurred during participation in any motorized race or contest of speed.
- an accident if the Member is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in a Driver's Education Program.
- expenses incurred for travel in any aircraft owned, leased or controlled by the Group, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by the Group if the aircraft may be used as the Group wishes for more than 10 straight days, or more than 15 days in any year.
- Injury or Sickness, occurring while the insured is serving on full-time active duty in the Armed Forces of any country or international authority.
- Hospital Confinement, surgery, treatment, service or supply for which:
  - the charge is payable or reimbursable by or through a plan or program of any governmental agency;
  - or charges which would not have been made if the person had no insurance.
- Injury as a result of a commission of a felony.
- attempted suicide or intentionally self-inflicted Injury, while sane or insane.
- eyeglasses, contact lenses, hearing aids, or examinations for prescription or fitting thereof.
- cosmetic or plastic surgery except:
  - when necessary as a result of an Injury or Sickness occurring while insured; or
  - reconstructive surgery when such service is incidental to or follows surgery resulting from Injury or Sickness.
- Hospital Confinement, care or treatment which is not recommended and approved by a Physician.
- private Hospital rooms and/or private duty nursing unless determined by the utilization review Physician to be Medically Necessary.
- obesity/bariatric surgery.
- physical examinations unless required because of Injury or Sickness.
- dental expenses unless the result of an accident to sound natural teeth or alleviation of sudden unexpected dental pain, then the benefit is limited to the amount shown in The Schedule.
- expenses incurred while operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which you have been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state and or country in which the Accident occurred.
- claim payments which are illegal under applicable law.
- any and all expenses incurred for medical services or treatment in the insured's country of permanent residence.
- expenses incurred if the original or ancillary purpose of your trip is to obtain medical treatment.
- routine maternity treatment.
- treatment of an Injury or Sickness which is caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action.
- 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 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; or
  - 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.

  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 the U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.
- hearing aids, unless lost or stolen.
- eyeglass lenses and frames and contact lenses, unless lost or stolen.
- abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.

General Limitations

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

- to the extent that payment is unlawful where 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.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- treatment or care of a person by a Physician or Nurse, if the Physician or Nurse is a member of the insured's immediate family or ordinarily resides with the insured.

HC-EXC358 01-20

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), occupational disease law, any employer's liability insurance or similar type of law or 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-SUB126 01-20

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 provider. When you authorize the payment of your healthcare benefits to a 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 provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a 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 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 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 Emergency Medical Illness and Injury 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-POB122 11-17

Termination Of Insurance

Members

Your insurance will cease on the earliest date below:

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

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 in an Eligible class as defined in Eligibility section or cease to qualify for the insurance.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made the required contribution for the insurance, if any.
- 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.

HC-TRM175 01-20

Medical Benefits Extension

During Hospital Confinement Upon Policy Cancellation

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

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

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

HC-BEX59 01-20

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.

All references in this section to "Employer" shall be deemed to mean "Group" and all references to "Employee" shall be deemed to mean "Member".

HC-FED1 10-10
V2

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

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.

HC-FED67 09-14

Coordination of Benefits with Medicare U.S.

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 Member, and your Employer has fewer than 100 Members.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Member, and your Employer has fewer than 20 Members.
- 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 Member. 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 Member, and your Employer has 100 or more Members.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Member, and your Employer has 20 or more Members.
- 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 Member. This plan is the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

Domestic Partners

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

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

Failure to Enroll in Medicare

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

Assistance with Medicare Questions

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

HC-FED103 11-18

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

Claim Determination Procedures under ERISA

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

Procedures Regarding Medical Necessity Determinations

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

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

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

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

Preservice Determinations

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

specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's reviewer, in consultation with the treating health care professional, will decide if 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: the specific reason or reasons for the adverse determination; 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 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 judgement for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; 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

ERISA Required Information

The name of the Plan is:

Contact your employer

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

Contact your employer

Employer Identification Number (EIN):	Plan Number:
Contact your employer	Contact your employer

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 Contact your employer

The Plan's fiscal year ends on Contact your employer

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

Notice of an Appeal or a Grievance

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

HC-SPP4 04-10
V1

Appointment of Authorized Representative

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

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

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

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

HC-AAR1 01-17

When You Have A Complaint Or Appeal

For the purposes of this section, any reference to "you", "your" or "Member" 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 and 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, or contractual benefits,

you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service toll-free number that appears on your ID card, explanation of benefits or claim form.

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 can start the appeals procedure.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 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, and the reduction or termination in coverage will occur before the end of the period of time or number of treatments that Cigna 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. Appeals may be submitted to the following address:

Cigna
Attn: Appeals Department
P.O. Box 15800
Wilmington, DE 19850

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 to register your appeal by telephone. Call us at the toll-free number on your ID card, explanation of benefits or claim form.

Level One Appeal

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 in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a 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.

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 function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

If the appeal involves a coverage decision based on issues of Medical Necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. For all other coverage plan-related appeals, a second level review will be conducted by someone who was not involved in any previous decision related to your appeal, and not a subordinate of previous decision makers. Provide all relevant documentation with your second level appeal request.

For required preservice and concurrent care coverage determinations, the review will be completed within 15 calendar days. For postservice claims, the review will be completed within 30 calendar days. 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 by the Committee to complete the review.

You will be notified in writing of the decision within five days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

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 function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review of Medical Appeals - IHCAP

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Health Care Appeals Program (IHCAP). The IHCAP is conducted by an Independent Utilization Review Organization (IURO) assigned by the State of Delaware. A decision to use this level of appeal will not affect the claimant's rights to any other

benefits under the plan. If the subject of an IHCAP request is appropriate for Arbitration, the Delaware Insurance Department will advise the Participant or his/her authorized representative of the Arbitration procedure

There is no charge for you to initiate the Independent Review of Medical Appeals (IHCAP) independent review process. Cigna will abide by the decision of the Independent Utilization Review Organization. In order to request a referral to an Independent Utilization Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within four months of your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Utilization Review Organization.

The Independent Utilization Review Organization will render an opinion and provide written notice of its decision to the Participant or his/her authorized representative, the carrier and the Delaware Insurance Department within 45 calendar days of its receipt of the appeal. When requested and when the Participant suffers from a condition that poses an imminent, emergent or serious threat or has an emergency medical condition, the review shall be completed within 72 hours of the IURO's receipt of the appeal with immediate notification. The IURO will provide written confirmation of its decision to the Participant or his/her authorized representative, the carrier, and the Delaware Insurance Department within 1 calendar day after the immediate notification.

Assistance from the State of Delaware

You have the right to appeal a claim denial for non-medical reasons to the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services which are in addition to, but do not replace, your right to appeal this decision. You can contact the Delaware Insurance Department for information about an appeal or mediation by calling the Consumer Services Division at (800) 282-8611 or (302) 739-4251.

All requests for mediation or arbitration must be filed within 60 days from the date you receive this notice otherwise this decision will be final.

Independent Review of Administrative Appeals - Arbitration

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding the denial of claims based on grounds other than Medical Necessity or appropriateness, you may request that your appeal be referred to Arbitration by submitting the Petition for Arbitration and supporting documentation to the Delaware Insurance Department. A decision to use this level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is a $75 filing fee for you to initiate the Arbitration process; if the arbitrator rules in your favor; Cigna will reimburse you for the $75 filing fee. Cigna will abide by the decision of the Arbitrator. In order to request a referral to Arbitration, certain conditions apply. The reason for the denial must be based on grounds other than Medical Necessity or appropriateness, such as administrative, eligibility or benefit coverage limits or exclusions.

To request a review, you must submit the Petition for Arbitration and supporting documentation within 60 days of your receipt of Cigna's level two appeal review denial to the Delaware Insurance Department.

If the subject of an Arbitration request is appropriate for IHCAP review, the Petition for Arbitration will be treated as an IHCAP appeal to determine if the IHCAP appeal is timely filed. The Delaware Insurance Department may summarily dismiss a Petition for Arbitration if it determines the subject is not appropriate for Arbitration or IHCAP or is meritless on its face.

The Arbitrator will render a decision and mail a copy of the decision to the Participant and his/her authorized representative within 45 calendar days of the filing of the Petition. The Arbitrator's decision shall include allowable charges and payments for each service subject to arbitration for a period that will end on the 360th day after the date of the Arbitrator's decision.

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: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

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 or 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 level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action. However, no action will be brought at all unless brought within three years after proof of claim is required under the plan.

HC-APL363 01-20

Definitions

Accident

A sudden, unforeseeable, external event that results, directly and independently of all other causes, in an Injury and meets all of the following conditions:

- occurs while the insured is insured under this Policy;
- is not contributed to by disease, Sickness, or mental or bodily infirmity;
- is not otherwise excluded under the terms of the policy.

HC-DFS1058 11-17

Active Service

You will be considered in Active Service:

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

HC-DFS1384 01-20

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 11-17
V8

Dental Emergency

Dental Emergency is defined as a type of medical emergency that involves a dental condition of recent onset and severity, which would lead a prudent layperson possessing an average knowledge of dentistry, to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection.

This also includes accidental dental treatment of an Injury to sound, natural teeth.

HC-DFS1061 11-17

Dependent

Dependents are:

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

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

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

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

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

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

HC-DFS1385 01-20

Domestic Partner

A Domestic Partner is defined as a person of the same or the 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.

HC-DFS1386 01-20

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, in 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-DFS1398 01-20

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-DFS1387 01-20

Expense Incurred

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

HC-DFS10 11-17
V7

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 11-17
V7

Group

The term Group means an eligible organization or plan sponsor that has elected to subscribe to the Trust to which this policy is issued.

HC-DFS1393 01-20

Hospital

The term Hospital means:

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

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-DFS1081 11-17

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.

HC-DFS1082 11-17

Injury - for Emergency Medical Illness and Injury

The term Injury means an accidental bodily injury.

HC-DFS1069 11-17

Maintenance Treatment

The term Maintenance Treatment means:

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

HC-DFS1435 01-20

Maximum Reimbursable Charge – Services Inside the United States Emergency Medical Illness and Injury

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 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-DFS1389 01-20

Maximum Reimbursable Charge - Services Outside the United States - Emergency Medical Illness and Injury

The Maximum Reimbursable Charge for covered services outside the United States is determined based on the lesser of:

- the charges contracted or otherwise agreed between the provider and Cigna; or
- the charge that a provider most often charges patients for the service or procedure; or
- the customary charge for the service or procedure as determined by Cigna based upon the range of charges made

for the service or procedure by most providers in the general geographic area where the service is rendered or the procedure performed.

Cigna is not obligated to pay excessive charges.

The percentage 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-DFS1390 01-20

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 11-17
V8

Medically Necessary/Medical Necessity

Health care services, supplies and medications provided for the purpose of 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 a Sickness, 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-DFS1391 01-20

Medicare

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

HC-DFS17 11-17
V7

Member

The term Member means a full-time employee or corporate director as determined by the Group who is currently in Active Service who is traveling outside their country of residence or permanent assignment for no more than 180 consecutive days per trip.

HC-DFS1388 01-20

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.

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

HC-DFS21 11-17
V8

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse or equivalent.

HC-DFS1072 11-17

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 11-17
V9

Preventive Treatment

The term Preventive Treatment means:

- treatment rendered to prevent disease or its recurrence.

HC-DFS1436 01-20

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 or equivalent.

HC-DFS1073 11-17

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 11-17
V3

Sickness

The term Sickness means a physical or mental illness and substance use disorder. It also includes non-routine maternity care. 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-DFS1074 11-17

Sojourn Travel

The Sojourn Travel benefit covers personal trip(s) directly connected before, after or during a business trip.

When coverage is provided for Sojourn Travel, the time period covered is shown in The Schedule.

HC-DFS1394 01-20

United States

The United States means the 50 States, the District of Columbia, and Puerto Rico.

HC-DFS1400 01-20

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 11-17
V10