Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY
a Cigna Company (called Cigna)
CERTIFICATE RIDER

No. HIMED2ET23

Policyholder: JPMorgan Chase & Co.

Rider Eligibility: Each Employee who is located in Hawaii

Policy No. or Nos. 3174696-HAWAI

EFFECTIVE DATE: January 1, 2023

You will become insured on the date you become eligible if you are in Active Service on that date or if you are not in Active Service on that date due to your health status.

This certificate rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified above. This rider replaces any other issued to you previously.

Additionally, the provisions identified in this rider only apply to:

(a) Benefit plans made available to you and/or your Dependents by your Employer;
(b) Benefit plans for which you and/or your Dependents are eligible;
(c) Benefit plans which you have elected for you and/or your Dependents;
(d) Benefit plans which are currently effective for you and/or your Dependents.

The provisions set forth in this certificate rider comply with the legislative requirements of Hawaii regarding group insurance plans covering insureds located in Hawaii. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Geneva Cambell Brown, Corporate Secretary

HC-RDR117 10-17

Preferred Provider Medical Benefits
The Schedule

For You and Your Dependents

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule.

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- provider charges in excess of the Maximum Reimbursable Charge.

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums will cross-accumulate between In- and Out-of-Network. All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
The Percentage of Covered Expenses the Plan Pays	90%	70% of the Maximum Reimbursable Charge
Calendar Year Deductible		
Individual	$100 per person	$100 per person
Family Maximum	$300 per family	$300 per family
Out-of-Pocket Maximum		
Individual	$2,000 per person	$2,000 per person
Family Maximum	$3,000 per family	$3,000 per family

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Primary Care Physician's Services		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Consultant and Referral Physician's Services		
Note: OB/GYN providers will be considered either as a PCP or Specialist.		
Surgery Performed In the Physician's Office		
Primary Care Physician	90%	Plan deductible, then 70%
Specialty Care Physician	90%	Plan deductible, then 70%
Second Opinion Consultations (provided on a voluntary basis)		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Allergy Treatment/Injections		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Allergy Serum (dispensed by the Physician in the office)		
Primary Care Physician	90%	Plan deductible, then 70%
Specialty Care Physician	90%	Plan deductible, then 70%
Preventive Care		
Routine Preventive Care – all ages		
Primary Care Physician's Office Visit	100%	70% after plan deductible for ages 6 and over; ages 5 and under covered at 70%.
Specialty Care Physician's Office Visit	100%	70% after plan deductible for ages 6 and over; ages 5 and under covered at 70%.
Immunizations – all ages		
Primary Care Physician's Office Visit	100%	70%, for children through age 5, otherwise refer to your certificate
Specialty Care Physician's Office Visit	100%	70%, for children through age 5, otherwise refer to your certificate

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mammograms Preventive Care Related Services (i.e. "routine" services) Diagnostic Related Services (i.e. "non-routine" services)	100% Subject to the plan's x-ray benefit & lab benefit; based on place of service	100% Plan deductible, then 70%
Inpatient Hospital - Facility Services	90%	Plan deductible, then 70%
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	90%	Plan deductible, then 70%
Inpatient Hospital Physician's Visits/Consultations	90%	Plan deductible, then 70%
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	90%	Plan deductible, then 70%
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	90%	Plan deductible, then 70%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services		
Hospital Emergency Room Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.	90%	90%
Urgent Care Facility or Outpatient Facility Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the UC visit.	Plan deductible, then 90%	Plan deductible, then 90%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER/UC visit		
Emergency Room Care	90%	90%
Urgent Care	Plan deductible, then 90%	Plan deductible, then 90%
Ambulance	Plan deductible, then 90%	Plan deductible, then 90%
Skilled Nursing Facility Calendar Year Maximum: 120 days	90%	Plan deductible, then 70%
Inpatient Services at Other Health Care Facilities Includes: Rehabilitation Hospital and Sub Acute Facilities Calendar Year Maximum: 120 day	90%	Plan deductible, then 70%
Laboratory Services		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Outpatient Hospital Facility	90%	Plan deductible, then 70%
Independent Lab facility	90%	Plan deductible, then 70%
Radiology Services		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Outpatient Hospital Facility	90%	Plan deductible, then 70%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Inpatient Facility	90%	Plan deductible, then 70%
Outpatient Facility	90%	Plan deductible, then 70%
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: 20 days for each therapy Includes: Pulmonary Rehab Cognitive Therapy Calendar Year Maximum: 60 days for each therapy Includes: Aural Therapy Physical Therapy Speech Therapy Occupational Therapy		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Outpatient Cardiac Rehabilitation Calendar Year Maximum: 36 days		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Chiropractic Care Calendar Year Maximum: Unlimited		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Home Health Care Calendar Year Maximum: 150 days (includes outpatient private nursing when approved as Medically Necessary)	100%	$50 Home Health Care Deductible, then 75%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Hospice Lifetime Maximum: Unlimited		
Inpatient Services	100%	Plan deductible, then 70%
Outpatient Services (same coinsurance level as Home Health Care)	100%	Plan deductible, then 70%
Bereavement Counseling Services Provided as part of Hospice Care		
Inpatient	100%	Plan deductible, then 70%
Outpatient	100%	Plan deductible, then 70%
Services Provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Maternity Care Services		
Initial Visit to Confirm Pregnancy		
Note: OB/GYN providers will be considered either as a PCP or Specialist.		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	90%	Plan deductible, then 70%
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Delivery – Facility (Inpatient Hospital, Birthing Center)	90%	Plan deductible, then 70%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Women's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling		
Note: Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a Physician. Diaphragms also are covered when services are provided in the Physician's office.		
Primary Care Physician	100%	Plan deductible, then 70%
Specialty Care Physician	100%	Plan deductible, then 70%
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)		
Primary Care Physician's Office Visit	100%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	100%	Plan deductible, then 70%
Inpatient Facility	100%	Plan deductible, then 70%
Outpatient Facility	100%	Plan deductible, then 70%
Inpatient Professional Services Radiologist, Pathologist and Anesthesiologist	100%	Plan deductible, then 70%
Outpatient Professional Services Radiologist, Pathologist and Anesthesiologist	100%	Plan deductible, then 70%
Men's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling		
Primary Care Physician	90%	Plan deductible, then 70%
Specialty Care Physician	90%	Plan deductible, then 70%
Surgical Sterilization Procedures for Vasectomy (excludes reversals)		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Inpatient Facility	90%	Plan deductible, then 70%
Outpatient Facility	90%	Plan deductible, then 70%
Inpatient Professional Services Radiologist, Pathologist and Anesthesiologist	90%	Plan deductible, then 70%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Professional Services Radiologist, Pathologist and Anesthesiologist	90%	Plan deductible, then 70%
Infertility Treatment Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination, GIFT, ZIFT, etc. • In-vitro unlimited attempts per lifetime.		
Physician's Office Visit (Lab and Radiology Tests, Counseling)		
Primary Care Physician	90%	Plan deductible, then 70%
Specialty Care Physician	90%	Plan deductible, then 70%
Inpatient Facility	90%	Plan deductible, then 70%
Outpatient Facility	90%	Plan deductible, then 70%
Inpatient Professional Services Radiologist, Pathologist and Anesthesiologist	90%	Plan deductible, then 70%
Outpatient Professional Services Radiologist, Pathologist and Anesthesiologist	90%	Plan deductible, then 70%
Lifetime Maximum for services other than In vitro: Unlimited Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).		
Organ Transplant Includes all medically appropriate, non-experimental transplants		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Inpatient Facility	100% at Lifesource center, otherwise plan deductible, then 90%	Plan deductible, then 70%
Inpatient Professional Services Radiologist, Pathologist and Anesthesiologist	100% at Lifesource center, otherwise plan deductible, then 90%	Plan deductible, then 70%
Lifetime Travel Maximum: $10,000 per transplant	100% (only available when using Lifesource facility)	In-Network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
External Prosthetic Appliances Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 70%
Hearing Aids Calendar Year Maximum: 2 devices per 36 months	Plan deductible, then 90%	Plan deductible, then 70%
Outpatient Dialysis Services		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Outpatient Facility Services	90%	Plan deductible, then 70%
Outpatient Professional Services	90%	Plan deductible, then 70%
Home Setting	100%	Plan deductible, then 75%
Nutritional Evaluation Calendar Year Maximum: 3 visits per person, however the 3 visit limit will not apply to treatment of diabetes.		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Inpatient Facility	90%	Plan deductible, then 70%
Outpatient Facility	90%	Plan deductible, then 70%
Inpatient Professional Services Radiologist, Pathologist and Anesthesiologist	90%	Plan deductible, then 70%
Outpatient Professional Services Radiologist, Pathologist and Anesthesiologist	90%	Plan deductible, then 70%
Nutritional Formulas Calendar Year Maximum: Unlimited	Plan deductible, then 90%	Plan deductible, then 70%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Obesity/Bariatric Surgery **Note:** Coverage is provided subject to Medical Necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of the certificate.		
Primary Care Physician's Office Visit	90%	Plan deductible, then 70%
Specialty Care Physician's Office Visit	90%	Plan deductible, then 70%
Inpatient Facility	90%	Plan deductible, then 70%
Outpatient Facility	90%	Plan deductible, then 70%
Inpatient Professional Services Radiologist, Pathologist and Anesthesiologist	90%	Plan deductible, then 70%
Outpatient Professional Services Radiologist, Pathologist and Anesthesiologist	90%	Plan deductible, then 70%
Surgical Professional Services Lifetime Maximum: Unlimited		
Mental Health		
Inpatient	90%	Plan deductible, then 70%
Outpatient (Includes Individual, Group and Intensive Outpatient)		
Physician's Office Visit	90%	Plan deductible, then 70%
Outpatient Facility	90%	Plan deductible, then 70%
Substance Abuse		
Inpatient	90%	Plan deductible, then 70%
Outpatient (Includes Individual and Intensive Outpatient)		
Physician's Office Visit	90%	Plan deductible, then 70%
Outpatient Facility	90%	Plan deductible, then 70%

Medical Care Benefits

THE SCHEDULE

CERTIFICATION REQUIREMENTS - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

- as a registered bed patient;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse
- for Mental Health or Substance Abuse Residential Treatment Services.

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

When PAC is not received prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission, the following penalty will be applied:

- Covered Expenses incurred will be paid at 70%, until a maximum penalty of $400 per admission or $1,000 per calendar year is reached.

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

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

Eligibility – Effective Date

Eligibility for Employee Insurance

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

- you are in a Class of Eligible Employees; and
- you work at least 20 hours a week for 4 consecutive weeks.

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

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

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

Change in Family Status

You may possibly be eligible to change your original selection of benefits when a change in your family status occurs. Consult your Employer for details.

Eligibility for Dependent Insurance

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

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

Waiting Period

Full-time employees, coverage begins on the first of the month following the date of hire.

For employees scheduled to work at least 20 hours, but less than 40 hours per week coverage begins the first of the month following 60 days from the date of hire.

Classes of Eligible Employees

Each Employee who is located in Hawaii

Effective Date of Employee Insurance

You will become insured on the next enrollment date after you complete the waiting period.

Late Entrant

Not applicable

Covered Expenses

- charges for Medically Necessary diabetes supplies, equipment, and education when prescribed by a health care professional authorized to prescribe these benefits. Self-management and education visits will be treated the same as any other office visit.
- charges for contraceptive services and prescription contraceptives. Contraceptive services are those intended to promote effective use of prescription as well as nonprescription contraceptive supplies and devices to prevent unwanted pregnancy. These services and supplies must be provided by a Physician, Physician's assistant, nurse practitioner, certified nurse midwife, nurse, or a person supervised by a Physician.
- charges for Mental Health which is defined as a syndrome of clinically significant psychological, biological, or behavioral abnormalities that result in personal distress or suffering, impairment of capacity for functioning, or both as defined in the most recent publications of the:
  - Diagnostic and Statistical Manual of the American Psychiatric Association (DSM), or the

- International Classification of Disease
- charges for the use of telecommunications services and enhanced services to deliver health care and information to parties separated by distance. Telehealth benefits include a Hospital's angiogram transmission to another medical facility; x-ray transmissions from one island to another; emergency room consultation between a Hospital and a medical center; and telehealth facilities at a medical center. It does not include standard telephone and/or fax transmissions in the absence of other integrated information and data.
- charges for screening by low-dose mammography for occult breast cancer to include: an annual mammogram for women forty and older; and an annual mammogram for women at any age if there is a history of breast cancer present for her, her mother or her sister and if a test is ordered by her Physician.
- charges for medical foods and low protein modified food products for the treatment of an inborn error of metabolism provided they are prescribed as Medically Necessary for the therapeutic treatment of an inborn error of metabolism and are consumed or administered enterally under the supervision of a licensed Physician.
  - an inborn error of metabolism is a disease caused by an inherited abnormality of the body chemistry of a person that is characterized by deficient metabolism, originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate, or fat. Low protein modified food products are food products that are specially formulated to have less than one gram of protein per serving; are prescribed or ordered by a Physician as Medically Necessary for dietary treatment of an inborn error of metabolism; and do not include a food that is naturally low in protein. Medical foods are foods that are formulated to be consumed or administered enterally under the supervision of a Physician and are intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below for a Dependent child who is age 5 or less for charges made for Child Health Supervision Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

- a history;
- physical examination;
- development assessment;
- anticipatory guidance; and
- appropriate immunizations and laboratory tests;

excluding any charges for:

- more than one visit to one provider for Child Health Supervision Services at each of the Approximate Age Intervals up to a total of 12 visits for each Dependent child;
- services for which benefits are otherwise provided under this Covered Expenses section;
- services for which benefits are not payable according to the Expenses Not Covered section.

It is provided that any Deductible that would otherwise apply will be waived for those Covered Expenses incurred for Child Health Supervision Services.

Approximate Age Intervals are: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years and 5 years.

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

Infertility Services

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

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are specifically excluded infertility services:

- reversal of male and female voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges and services;
- cryopreservation of donor sperm and eggs; and

- any experimental, investigational or unproven infertility procedures or therapies.

Exclusions, Expenses Not Covered and General Limitations

Any exclusions in your certificate for the following are **NULL and VOID:**

- pre-existing conditions;
- acts of war, riot or insurrection;
- family members who provide a service, therapy or treatment intended primarily to improve or maintain general physical condition;
- treatment denied by the Medicare Plan or a Primary Plan; or
- Home Health Services and Hospice Services not including services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house.

The following exclusions are added to your certificate:

- Home Health Services and Hospice Services do not include services by a person who is a parent, child or spouse who normally resides in your house or your Dependent's house.
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

Termination

Termination of Insurance - Employees

Your insurance will cease on the earliest date below:

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

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

Temporary Layoff or Leave of Absence

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

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued for at least 3 months following the month of disability while you remain totally and continuously disabled as a result of the Injury or Sickness. However, after this period of 3 months, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

When You Have A Complaint Or An 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 you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Services toll-free number that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If you are not satisfied with the results of a coverage decision, you can start the Appeals Procedure.

Internal Appeals Procedure

Cigna has a one step appeal procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice, to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

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 Benefit Identification card, explanation of benefits or claim form.

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

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

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection

with the appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum 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 nonauthorization of an admission or continuing inpatient Hospital stay.

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

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.

Cigna will send notice of its final internal determination to you, your appointed representative, if applicable, your treating provider, and the commissioner. The notice shall include the following information regarding your rights and procedures:

- your right to request an external review;
- the deadline for requesting an external review;
- instructions on how to request an external review; and
- where to submit the request for an external review.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. 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 charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent 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 130 days of your receipt of Cigna's appeal review denial. Cigna will within 5 business days after receipt of the request then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and when a delay would be detrimental to your condition, as determined by Cigna's Physician Reviewer, the review shall be completed within 72 hours.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; 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 and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

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

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit 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 appeal processes. However, no action will be brought at all unless brought within three years after proof of claim is required under the Plan. However, no action will be brought at all unless brought within three years after a claim is submitted for In-Network services or within

three years after proof of claim is required under the Plan for Out-of-Network services.

Definitions

Active Service

You will be considered in Active Service:

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

Dependent

The following are considered Dependents under this plan:

- any adopted child or a child placed for adoption. This means the assumption and retention of a legal obligation for total or partial support in anticipation of the adoption of the child.

Employee

The term Employee means an Employee of the Employer who works at least 20 hours a week for 4 consecutive weeks.