Champlain College Inc

MEDICAL BENEFITS ABROAD®
Premier Plan

EFFECTIVE DATE: May 8, 2020

CN001
03354B

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

Printed in U.S.A.

Table of Contents

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

CIGNA HEALTH AND LIFE INSURANCE COMPANY

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

POLICYHOLDER: Wilmington Trust National Association, Champlain College Inc

GROUP POLICY(S) — COVERAGE
03354B - MEDICAL BENEFITS ABROAD®

EFFECTIVE DATE: May 8, 2020

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

Timely Filing of 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 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 365 days, the claim will not be considered valid and will be denied.

Timely Filing of Claims - for Accidental Death and Dismemberment (AD&D)

You must provide written proof of loss to us, or proof by any other electronic/telephonic means authorized by us, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by us, must be given not more than one year after the 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is provided outside of these time limits, the claim will be denied. These time limits will not apply due to lack of legal capacity.

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-CLM120 11-17

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You are eligible for insurance if:

- you are in a Class of Eligible Employees and covered under your Participating Employer's group health plan or other comprehensive health coverage in your country of residence or permanent assignment if outside the United States;
- you are an eligible, full-time Employee of the Participating Employer;
- 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, your Participating Employer;
- you normally work at least 30 hours a week; and
- you pay any required contribution.

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

Classes of Eligible Employees

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

Effective Date of Employee Insurance

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

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Medical Benefits Abroad®

The Schedule

Emergency Medical Illness and Injury Benefits

For You

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

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 charges for Covered Expenses that an insured person is required to pay under the plan.

Deductibles

Deductibles are expenses to be paid by you. 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

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

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

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

Co-Surgeon

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

BENEFIT HIGHLIGHTS	
Calendar Year Emergency Medical Illness and Injury Benefit Maximum	$200,000

BENEFIT HIGHLIGHTS	
The Percentage of Covered Expenses the Plan Pays	100% of the Maximum Reimbursable Charge (see below)
Maximum Reimbursable Charge **Services Inside 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 schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for 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 the Insurance Company. 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 the Insurance Company; 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 the Insurance Company 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. The Insurance Company 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%
Calendar Year Deductible	$25
Out-of-Pocket Maximum	$25

BENEFIT HIGHLIGHTS	
Physician's Services Physician's Office Visit Surgery Performed in the Physician's Office	 Plan deductible, then the plan pays 100% Plan deductible, then the plan pays 100%
Inpatient Hospital - Facility Services Semi-Private Room and Board Private Room Special Care Units (ICU/CCU)	Plan deductible, then 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	Plan deductible, then the plan pays 100%
Inpatient Hospital Physician's Visits/Consultations	Plan deductible, then the plan pays 100%
Inpatient Professional Services Radiologist, Pathologist, Anesthesiologist	Plan deductible, then the plan pays 100%
Outpatient Professional Services Surgeon, Radiologist, Pathologist, Anesthesiologist	Plan deductible, then the plan pays 100%
Ambulance	Plan deductible, then the plan pays 100%
Laboratory Services Physician's Office Visit Outpatient Hospital Facility Independent Lab Facility	Plan deductible, then the plan pays 100%
Radiology Services Physician's Office Visit Outpatient Hospital Facility	Plan deductible, then the plan pays 100%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans) Physician's Office Visit Inpatient Facility Outpatient Facility	Plan deductible, then the plan pays 100%
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)	Plan deductible, then the plan pays 100%

BENEFIT HIGHLIGHTS	
Medical Pharmaceutical Products Coverage also includes replacement of lost medical pharmaceutical products	Plan deductible, then 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	Plan deductible, then the plan pays 100%
War Risk Benefit	Not Covered
Personal Deviation (Sojourn) Benefit	Not Covered
Emergency Medical Evacuation & Repatriation Benefit Maximum: $100,000	The plan pays 100%

BENEFIT HIGHLIGHTS	
Accidental Death and Dismemberment Benefits	
Amount of Principal Sum	$100,000
War Risk	Not Covered
Aggregate Limit of Liability For all covered persons involved in any one Accident **This includes forms of transportation such as air, bus, train, and boat**	Not more than $500,000 will be paid for all Covered Losses for all covered persons as the result of any one Accident. If this amount does not allow all covered persons to be paid the amounts this policy otherwise provides, the amount paid for each Loss bears to the Aggregate Limit of Liability.
Table of Benefits for Accidental Losses	**% of Principal Sum**
Loss of Life or Two or more members	100%
Loss of Speech and Hearing	100%
Loss of Speech or Hearing	One-half (1/2) the Principal Sum
Loss of One member	One-half (1/2) the Principal Sum
Thumb and index finger from the same hand	One-fourth (1/4) the Principal Sum
Such payment shall be in addition to any other indemnity payable as of the date of loss, but only one (1) amount, the larger applicable amount, shall be payable for all such losses resulting from one accident. The "Principal Sum" is the amount specified as such in The Schedule.	
Member: shall mean a hand, foot, or eye	
Loss shall mean, with respect to: • hands and feet, actual severance through or above wrist or ankle joints; • with respect to eyes, entire irrecoverable loss of sight; • with respect to speech, the total irrecoverable loss of speech which does not allow audible communications in any degree; • with respect to hearing which cannot be corrected by any hearing aid or device; • with respect to thumb and index finger means complete severance through or above the metacarpophalangeal joints, (the joints between the fingers and the hand).	

Certification Requirements -Emergency Medical Illness and Injury Benefits

Required for all U.S. 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.

Covered Expenses

Emergency Medical Illness and Injury Benefits

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are made for Emergency Services or Urgent Care for the care and treatment of an Injury or a Sickness, as determined by Cigna. **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. A 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. 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 Prosthetic/Medical Appliances

Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal 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 Evacuation/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 suffer a life-threatening/limb-threatening 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.

Emergency Evacuation

You must contact Cigna at the phone number indicated on your identification 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.

Emergency Family Travel

Arrangements and Confinement Visitation

If Cigna determines that you are 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.

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.

Repatriation following a Medical Evacuation

Covered Expenses

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

- if it is deemed Medically Necessary and appropriate by the Cigna medical director, you will be transferred to your permanent residence via a one-way economy airfare; or

- you 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 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.

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 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.

HC-COV622 11-17

Conditions of Coverage

Accidental Death and Dismemberment (AD&D) Benefits

This section describes the Conditions of Coverage under which benefits provided by the policy become payable. Any benefits are payable only once, even though more than one Condition of Coverage may apply. Please read these and the "Exclusions" sections in order to understand all of the terms, conditions and limitations of coverage.

We will pay benefits specified in The Schedule, subject to all applicable conditions and exclusions, if you suffer a Covered Loss caused, directly and independently of all other causes, by an Accident which occurs while you are traveling:

- on business of the Policyholder outside the Employee's home country; and
- in the course of the business of the Policyholder; and
- on a trip authorized in advance by the Policyholder; and
- away from the premises of the Policyholder.

For purposes of this coverage "Country of Permanent Assignment**"** means the Country where the Employee normally works.

Exclusions

Coverage for business travel is not provided during any of the following:

- normal commuting between your home and place of work;
- travel to another location where you are expected to be assigned for more than 180 days;
- any activity not authorized or organized, or not reimbursable, by the Policyholder;
- your Personal Deviation (Sojourn); or
- driving any vehicle or Private Passenger Automobile for pay or hire.

Business Travel Coverage is not in effect while you are performing job duties during work hours, and in a residence work area, which is specified in a written telecommuting agreement between you and your Employer.

Exposure and Disappearance Coverage

Cigna will pay benefits specified in The Schedule, subject to all applicable conditions and exclusions, if you suffer a Covered Loss which results, directly and independently of all other causes, from an Accident that causes you unavoidable

exposure to the elements following the forced landing, sinking, stranding or wrecking of a vehicle. If you disappear and are not found within one year from the date of wrecking, sinking or disappearance of the conveyance in which you were riding in the course of a trip which would otherwise be covered under the policy, it will be presumed that your death resulted directly and independently of all other causes from an Accident. Travel or trip must have been authorized in advance by the Policyholder.

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

- Injury, Sickness, dismemberment or death 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, dismemberment or death 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 Employee 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 Policyholder, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by the Policyholder if the aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year.
- Injury or Sickness, dismemberment or death, 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.

- expenses incurred during Personal Deviation (Sojourn) when not in conjunction with a business trip.
- claim payments which are illegal under applicable law.
- any and all expenses incurred for medical services or treatment or loss or dismemberment that occurs 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 or death and dismemberment 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 drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature. The plan or policy shall not deny coverage for a drug therapy or device as experimental, investigational and unproven if the drug therapy or device is otherwise approved by the FDA to be lawfully marketed and is recognized for treatment of the prescribed indication in a prescription drug reference compendium approved by the Insurance Commissioner or substantially accepted peer reviewed medical literature.
- 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-EXC292 11-17

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you (hereinafter 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-SUB109 11-17

Payment of Benefits

Assignment and Payment of Benefits

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

You may, however, authorize Cigna to pay any healthcare benefits under this policy to a 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, you are 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.

Accidental Death and Dismemberment (AD&D)

To Whom Payable

Death Benefits will be paid to the insured's named beneficiary, if any, on file at the time of payment. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the insured's estate. We may reduce the amount payable by any indebtedness due.

All other benefits unless otherwise stated in the policy, will be payable to the insured.

Any other accrued benefits which are unpaid at your death will, at our option, be paid either to your beneficiary or to the executor or administrator of your estate.

If we pay benefits to the executor or administrator of your estate or to a person who is incapable of giving a valid release, we may pay up to $750 to a relative by blood or marriage whom we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

Cigna will pay the Benefit Amount when it receives due proof that:

- you received an accidental bodily Injury while insured for this benefit; and
- as a direct result of that Injury, independently of all other causes, you sustained any loss shown in the "Table of Benefits for Accidental Losses"; and
- the loss occurred within 90 days after the date of that Injury.

The Benefit Amount for each loss will be your amount of Principal Sum determined from The Schedule multiplied by the percentage shown in the "Table of Benefits for Accidental Losses" for that loss. The maximum that will be paid for all losses resulting from injuries you receive in any one Accident will be your amount of Principal Sum.

HC-POB122 11-17

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance, 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.

HC-TRM126 11-17

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 is 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 you are covered for medical benefits under another group plan;
- 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-BEX53 11-17

Federal Requirements

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

HC-FED1 10-10

Coordination of Benefits with Medicare U.S.

If you 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 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 qualify for Medicare for any reason and are covered under this Plan due to your retirement or termination of employment.
- Disability: You qualify for Medicare due to a disability, you are an active Member, and your Employer has fewer than 100 Members.
- Age: You 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 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 qualify for Medicare due to a disability, you are an active Member, and your Employer has 100 or more Members.
- Age: You 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 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.

IMPORTANT: If you 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 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 your 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 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 if there is a loss of coverage under the Plan as a result of a qualifying event. You 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 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 Benefit Identification 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, you must submit a request for an appeal in writing, within 365 days of receipt of a denial notice, 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 Benefit Identification 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 fifteen 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; 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.

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, Cigna's review will be completed within 15 calendar days. For postservice claims, Cigna's 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.

Claim Appeal to 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-APL286 11-17

Accidental Death and Dismemberment (AD&D)

Appeals Procedure for Denied Claims

Whenever a claim is denied, there is the right to appeal the decision. A written request for appeal must be made to Cigna within 60 days from the date the denial was received. If a request is not made within that time, the right to appeal will have been waived.

Once a request has been received by Cigna, a prompt and complete review of the claim will take place. This review will give no deference to the original claim decision. It will not be made by the person who made the initial claim decision, or a subordinate of that person. During the review, the claimant (or the claimant's duly authorized representative) has the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by Cigna will be identified. Issues and comments that might affect the outcome of the review may also be submitted.

Cigna has 60 days from the date it receives a request to review the claim and provide its decision. Under special circumstances, Cigna may require more time to review the claim. If this should happen, Cigna must provide notice, in writing, that its review period has been extended for an additional 60 days. Once its review is complete, Cigna must state, in writing, the results of the review and indicate the Plan provisions upon which it based its decision.

HC-APL287 11-17

Definitions

Accident

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

- occurs while the insured is insured under this Policy;
- occurs under one of the "Conditions of Coverage";
- 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 your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1084 11-17

Bed and Board

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

HC-DFS2 11-17
V8

Covered Losses

We will pay the Benefit for any one of the Covered Losses listed in The Schedule, subject to all applicable conditions and exclusions, if the covered person suffers a Covered Loss resulting directly and independently of all other causes from an Accident within the applicable time period specified in The Schedule.

If the insured sustains more than one Covered Loss as a result of the same Accident, Cigna will pay the Benefit for the Covered Loss for which the largest benefit is payable. If the insured sustains more than one Covered Loss as a result of the same Accident, the total of Benefits Cigna will pay will not exceed the Principal Sum.

If an Accident causes the insured's death, the total of all Benefits Cigna will pay for Accidental Death and any other Covered Losses will not exceed the Principal Sum Accidental Death Benefit.

HC-DFS1060 11-17

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

Emergency Medical Condition

Emergency Medical Condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

HC-DFS394 11-17
V11

Emergency Services

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

HC-DFS393 11-17
V8

Employee

The term Employee means a full-time Employee who is currently in Active Service and working a minimum of 30 hours a week or member of the Participating Employer who is traveling on the business of, or at the expense of, the Participating Employer outside their country of residence or permanent assignment for no more than 180 consecutive days per one trip.

HC-DFS1068 11-17

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

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 Accidental Death and Dismemberment (AD&D)

Any bodily harm that results, directly and independently of all other causes, from an Accident.

HC-DFS1059 11-17

Injury - for Emergency Medical Illness and Injury

The term Injury means an accidental bodily injury.

HC-DFS1069 11-17

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 policyholder-selected percentage of a schedule developed by Cigna 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-DFS1070 11-17

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 the Insurance Company; 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 the Insurance Company 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.

The Insurance Company 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-DFS1075 11-17

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.

HC-DFS1071 11-17

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

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

Participating Employer

The term Participating Employer means an Employer or Employee organization as those terms are defined in ERISA and participating in the Trust to which this policy is issued.

HC-DFS1080 11-17

Personal Deviation (Sojourn)

An activity which:

- is neither reasonably related to or incidental to the purpose of travel for which coverage is provided by the policy; and
- the covered person performs before, during or after covered travel.

When coverage is provided during a Personal Deviation, the time period covered is shown in The Schedule.

HC-DFS1057 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

Private Passenger Automobile

A validly registered, four wheel private passenger car, including Participating Employer-owned cars, automobile campers, motor homes, station wagons, sport utility vehicles, pick-up trucks and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a taxicab, bus, or other public conveyance will not be considered a Private Passenger Automobile.

HC-DFS1062 11-17

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

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