Quinn, Emanuel, Urquhart & Sullivan, LLP

CALIFORNIA SCHEDULE OF COPAYMENTS

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This document printed in October, 2022 takes the place of any documents previously issued to you which described your benefits.

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Schedule of Copayments

For You and Your Dependents

*This Schedule of Copayments is a supplement to the Group Service Agreement provided to Members and is **not** intended as a complete summary of the services and benefits covered or excluded. It is recommended that Members review their Group Service Agreement for an exact description of the services and benefits which are covered, those which are excluded or limited, and other terms and conditions of coverage.*

Covered Services and Supplies	You or Your Dependents will pay the Copayment, then the plan will pay the percentage shown below
Primary Care Physician Services Office Visits Surgery performed in the Physician's Office	No charge after $10 per office visit copay
Specialty Physician Services Office Visits Surgery performed in the Physician's Office	No charge after $20 per office visit copay
Preventive Care	
Periodic Physical Evaluations for Adults	No charge
Well-Child Care	No charge
Routine Immunizations	No charge
Allergy Treatment/Injections	No charge after either the $10 PCP or $20 Specialist per office visit copay or the actual charge, whichever is less
Inpatient Hospital Services Semi-private Room and Board Laboratory, Radiology and other Diagnostic and Therapeutic Services Administered Drugs, Medications, Biologicals and Fluids Special Care Units Operating Room, Recovery Room Anesthesia Inhalation Therapy Radiation Therapy and Chemotherapy	No charge
Physician and Surgeon Charges	No charge

Covered Services and Supplies	You or Your Dependents will pay the Copayment, then the plan will pay the percentage shown below
Outpatient Facility Services Operating Room, Recovery Room Procedures Room and Treatment Room including: Laboratory and Radiology Services Administered Drugs, Medications, Biologicals and Fluids Anesthesia Inhalation Therapy	No charge after $100 per visit copay
Physician Services	No charge
Emergency Services	
Physician's Office	No charge after the $10 PCP or $20 Specialist per office visit copay
Hospital Emergency Room	No charge after $100 per visit copay The emergency room Copayment will be waived if you are admitted to a participating hospital directly from the emergency room
Urgent Care Facility or Outpatient Facility	No charge after $50 per visit copay The urgent care or Outpatient facility Copayment will be waived if you are admitted to a participating hospital directly from the urgent care facility
Ambulance	No charge
Inpatient Services at Other Participating Health Care Facilities Rehabilitation Hospital Skilled Nursing Facility and Sub-Acute Facilities Contract Year Maximum: 100 days	No charge
Laboratory and Radiology Services	
Physician's Office Visit	No charge
Outpatient Hospital Facility	No charge
Independent Facility	No charge
Advanced Radiological Imaging (MRI's, MRA's, CAT scans and PET scans)	
Physician's Office Visit	No charge
Inpatient Facility	No charge
Outpatient Facility	No charge

Covered Services and Supplies	You or Your Dependents will pay the Copayment, then the plan will pay the percentage shown below
Diabetic Services and Supplies	
Self management Courses and Training	No charge after the $10 PCP or $20 Specialist per office visit copay
Supplies	Provided under the Supplemental Prescription Drug Pharmacy Rider
Equipment	Same as Durable Medical Equipment Copayment per item
Insulin	Provided under the Supplemental Prescription Drug Pharmacy Rider
Rehabilitation Therapy, including Chiropractic Care Contract Year Maximum: Unlimited	No charge after the $10 PCP or $20 Specialist per office visit copay
Outpatient Cardiac Rehabilitation Services Contract Year Maximum: Unlimited	No charge after the $10 PCP or $20 Specialist per office visit copay
Hearing Aids Contract Year Maximum: Maximum of 2 devices per Lifetime Includes testing and fitting of hearing aid devices at Physician Office Visit cost share	No charge
Home Health Services Contract Year Maximum: 100 days	No charge
Hospice Services	
Inpatient Services	No charge
Outpatient Services	No charge
Nutritional Evaluation Contract Year Maximum: 3 visits per member, however the three visit limit will not apply to treatment of diabetes	No charge after the $10 PCP or $20 Specialist per office visit copay
Family Planning for Men	
Office Visits (Tests and Counseling)	No charge after the $10 PCP or $20 Specialist per office visit copay
Surgical Sterilization Procedures	Same as Inpatient Hospital Services, Outpatient Facility Services, Primary Care or Specialty Care Physician's Office Visit copayment, depending on facility used
Family Planning for Women	
Office Visits (Tests and Counseling)	No charge

Covered Services and Supplies	You or Your Dependents will pay the Copayment, then the plan will pay the percentage shown below
Surgical Sterilization Procedures	No charge
Maternity Care Services	
Pre-/Post-Delivery Exams	
Initial Visit to Confirm Pregnancy	No charge after the $10 PCP or $20 Specialist per office visit copay
All Other Visits	No charge
Delivery	No charge
Infertility Diagnosis	
Diagnostic services to establish cause or reason for infertility	No charge after the $10 PCP or $20 Specialist per office visit copay
Organ Transplant Travel Services Lifetime Maximum: $10,000	No charge
Durable Medical Equipment Contract Year Maximum: Unlimited	No charge
External Prosthetic Appliances and Orthotics Contract Year Maximum: Unlimited	No charge
Mental Health and Substance Use Disorder Services (MH/SUD)** (all MH/SUD, including Severe Mental Illness of a Member of any Age and Serious Emotional Disturbances of a Child)	
Inpatient Services (i.e. acute inpatient, inpatient substance abuse detoxification and residential treatment)	No charge
Outpatient Services	
Office Visit: (i.e. individual, family and group therapy)	No charge after $20 per office visit copay
All Other Outpatient: (i.e. partial hospitalization, applied behavior analysis, intensive outpatient therapy, outpatient substance abuse detoxification, and medication assisted treatment for opiate dependence)	No charge after $100 per visit copay

**Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the Healthplan Medical Director in accordance with the applicable mixed services claim guidelines.

Total Copayment Maximum*	
Individual	$1500
Family	$3000

* All Copayments paid by Member for Covered Services and Supplies other than Copayments paid for Prescription Drugs and Durable Medical Equipment (except for supplies for the management/treatment of diabetes) apply towards the Total Copayment Maximums.

Prescription Drug Benefits Schedule of Copayments For You and Your Dependents			
	Copayment **		
Pharmacy Benefits	**Retail Participating Pharmacy Copayment (applies to each 30 day supply)**	**Designated 90 Day Retail Pharmacy Copayment (applies to a 90 day supply)**	**Mail Order Participating Pharmacy (applies to each Prescription Order or refill)**
Tier 1 Generic * drugs on the Prescription Drug List	$10	$20	$20
Tier 2 Medically Necessary Name Brand drugs designated as preferred on the Prescription Drug List with no Generic equivalent (including supplies for the management and treatment of pediatric asthma) and Medically Necessary non-Prescription Drug List drugs*	$20	$40	$40
Tier 3 Non-Medically Necessary Name Brand drugs on the Prescription Drug List with a Generic equivalent and non-Prescription Drug List drugs and Non-Medically Necessary non-Formulary drugs*	$40	$80	$80
	***Designated as per generally-accepted industry sources and adopted by Healthplan**		

** **IMPORTANT** – The Limitations and Member Payments section in the Prescription Drug Rider contain additional information regarding applicable Copayments.

Total Out-of-Pocket Maximum	
Individual Member Total Out-of-Pocket Maximum	$1,500 per Contract year
Membership Unit Total Out-of-Pocket Maximum	$3,000 per Contract year

Supplemental Rider

This Supplemental Rider is part of the Cigna Healthcare of California, Inc. Group Service Agreement ("the Agreement") and subject to all of the terms, conditions and limitations contained therein. In consideration for an additional monthly fee incorporated into the Prepayment Fee, the following supplemental prescription drug benefit is added to the Agreement.

Prescription Drugs

I. Definitions

Copayment means the amount shown in the Prescription Drug Schedule of Copayments that you pay for certain Covered Services and Supplies. The Copayment may be a fixed dollar amount or a percentage of the amount Cigna charges the Group with respect to the Covered Service or Supply.

Designated 90 Day Retail Pharmacy – A retail Participating Pharmacy that has entered into an agreement with Healthplan, or with an entity contracting on Healthplan's behalf, to provide Members with an extended days' supply of Prescription Drugs or Related Supplies. The fact that a retail pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. New drugs are approved for the Prescription Drug List when there is proof of clinical efficacy. To be considered for inclusion in the Prescription Drug List, Prescription Drugs and Related Supplies must be reviewed by the P&T Committee. The P&T Committee meets at least quarterly. New Prescription Drugs and Related Supplies are frequently added to the Prescription Drug List, while others on the list may be deleted. The Prescription Drug List will be updated each time a change occurs.

The presence of a Prescription Drug and Related Supplies on the Prescription Drug List does not guarantee that the Member will be prescribed that Prescription Drug and Related Supplies by his/her Participating Physician for a particular medical condition.

You may contact Member Services at the toll-free number found on your Cigna HealthCare ID card to request a copy of the Prescription Drug List or to request information regarding whether a specific drug or drugs are on the Prescription Drug List. You can also access the Prescription Drug List through the Internet at www.cigna.com.

Coverage for certain Prescription Drugs and Related Supplies require your Participating Physician to obtain prior authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. The Healthplan shall also maintain an expeditious process by which Participating Physicians may obtain authorization for Medically Necessary non-Prescription Drug List Drug and Related Supplies. If the Member's Participating Physician reasonably believes that there is a Medically Necessary reason to prescribe a non-Prescription Drug List Drug and/or Related Supplies, or wishes to request coverage for a Prescription Drug and/or Related Supplies for which prior authorization is required, the Participating Physician should contact the Healthplan or complete the appropriate prior authorization form and fax it to the Healthplan to request coverage before the Prescription Drug and/or Related Supplies are written so that the Healthplan can evaluate the request and work with the Participating Physician and Participating Pharmacy. If the request is approved, the doctor will receive a fax confirmation. The length of the authorization will depend on the diagnosis and the Prescription Drug and/or Related Supplies. If the request is denied, your Participating Physician and you will be notified that coverage for the Prescription Drug and/or Related Supplies is not authorized.

If the Member is advised at the Participating Pharmacy that the prescription is for a non-Prescription Drug List Drug and/or Related Supplies and the Participating Provider has not contacted the Healthplan for authorization, the Participating Pharmacy will dispense the Prescription Drug and/or Related Supplies at the full retail cost of the non- Prescription Drug List drug. The Member may request that the Participating Pharmacy contact the Member's Participating Physician to request a change to a Prescription Drug List medication or submit a request to the Healthplan for coverage of the non-Prescription Drug List Drug and/or Related Supplies as Medically Necessary. If the Member's Participating Physician is not available or the Participating Pharmacy is not able to reach the Healthplan, all Participating Pharmacies have been instructed to dispense at least a three (3) day supply, but not more than a thirty (30) day supply at the applicable Copayment. If, after being contacted, the Member's Participating Physician reasonably believes a change to a Prescription Drug List Drug and/or Related Supplies is appropriate, the Healthplan will notify both the Member and the Participating Pharmacy. If, after consultation with the Member's Participating Physician, the non- Prescription Drug List Drug and/or Related Supplies is approved as Medically Necessary, the Member will continue to receive the non-

Prescription Drug List Drug and/ or Related Supplies at the applicable Copayment.

If the request for approval involves a Medically Necessary new non- Prescription Drug List Drug and/or Related Supplies or a refill non- Prescription Drug List Drug and/or Related Supplies where the Member has no more of the Prescription Drug and/or Related Supplies, the Healthplan will make a decision and communicate it to all parties by telephone on the same day as receipt of the request from the Member's Participating Physician but in any event not more than twenty-four (24) hours from the time of receipt. Requests for refills where the Member has more of the drug remaining will be made and communicated in writing to all parties within forty-eight (48) hours from the time of receipt of the request from the Member's Participating Physician. The length of the authorization will depend on the diagnosis and Prescription Drug and/or Related Supplies.

If the request is denied, your Participating Physician and you will be notified that coverage for the Prescription Drug and/or Related Supplies is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Agreement, by submitting a written request stating why the Prescription Drug and/or Related Supplies should be covered.

If you have questions about a specific Prescription Drug List exception or prior authorization request, you should call Member Services at the toll-free number on the Cigna HealthCare ID card. Healthplan shall not limit or exclude coverage for a Prescription Drug and/or Related Supplies for a Member if the drug had previously been approved for coverage by the Healthplan for a medical condition of the Member and the Member's Participating Physician continues to prescribe the drug for the medical condition, provided that the drug is appropriately prescribed, and is considered safe and effective for treating the Member's medical condition. Nothing shall preclude the Participating Physician from prescribing another drug, including a "generic" drug covered by Healthplan that is medically appropriate for the Member. This section does not apply to coverage for any drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA).

All newly approved Federal Drug Administration (FDA) drugs are designated as either non-preferred or non-Prescription Drug List Drugs until the P&T Committee evaluates the Prescription Drug clinically for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six (6) months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six (6) months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Individual Out-of-Pocket Maximum is the amount of Copayments you must pay out of your own pocket each Contract Year for covered Prescription Drugs and Related Supplies. When the Copayments you have paid for Prescription Drugs and Related Supplies, in a Contract Year equals the Individual Out-of-Pocket Maximum, you will not be required to pay any more Copayments for Prescription Drugs and Related Supplies for the remainder of that Contract Year.

When 3 Members in your membership unit have met their Individual Out-of-Pocket Maximum, and together meet the Membership Unit Out-of-Pocket Maximum, all Members in the Membership Unit will be considered to have met their Individual Out-of-Pocket Maximums for that Contract Year. The Individual and Membership Unit Out-of-Pocket Maximum amounts are shown in the Prescription Drug Schedule of Copayments.

Life-threatening means (i) disease or conditions where the likelihood of death is high unless the course of the disease is interrupted, and/or (ii) disease or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Participating Pharmacy means 1) a retail pharmacy which has contracted with the Healthplan to provide prescription services to Members; or 2) a mail order pharmacy which has contracted with the Healthplan to provide mail order prescription services to Members.

Prescription Drug means (i) a drug which has been approved by the Food and Drug Administration safety and efficacy; (ii) certain drugs approved under the Drug Efficacy Study Implementation review; (iii) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a prescription order.

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Participating Physician who is duly licensed to make such authorization within the course of such Participation Physician's professional practice or each authorized refill thereof.

Pharmacy & Therapeutics (P&T) Committee. A committee of Cigna HealthCare Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies, including prior authorization requirements.

Related Supplies means diabetic supplies (insulin needles and syringes, lancets, lancet puncture devices, ketone urine testing strips, blood glucose test strips and pen delivery systems for the administration of insulin), needles and syringes for injectables covered under this Prescription Drug benefit, nebulizers (including face masks and tubing), peak flow meters and inhaler spacers for the management and treatment of pediatric asthma and other conditions.

II. Services and Benefits

When ordered by a Participating Physician, a Member shall be entitled to purchase Medically Necessary Prescription Drugs and Related Supplies from Participating Pharmacies as designated by the Healthplan. Prescription Drugs and Related Supplies include coverage for the following:

Contraceptives - a variety of federal Food and Drug Administration approved prescription contraceptive methods.

Diabetic Supplies - insulin needles and syringes, lancets, lancet puncture devices, ketone urine testing strips, blood glucose test strips and pen delivery systems for the administration of insulin.

Needles and Syringes - for injectables covered under this Prescription Drug benefit.

Pediatric Asthma Supplies - nebulizers (including face masks and tubing), peak flow meters and inhaler spacers for the management and treatment of pediatric asthma.

Healthplan will also cover Medically Necessary Prescription Drugs and Related Supplies dispensed by a Participating Pharmacy, with a prescription issued to a Member by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When a Member is issued a prescription for a Prescription Drug and/or Related Supply as part of the rendering of Emergency Services and a Participating Pharmacy cannot reasonably fill such prescription, such prescription will be covered by Healthplan, subject to the provisions of this Rider.

Patient Assurance Program

Your plan offers additional discounts for certain covered Prescription Drug Products that are dispensed by a retail or home delivery Network Pharmacy included in what is known as the "Patient Assurance Program". As may be described elsewhere in this plan, from time to time the Healthplan may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your Out-of-Pocket Expenses for certain covered Prescription Drug Products for which the Healthplan directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by the Healthplan for certain covered Prescription Drug Products included in the Patient Assurance Program is applied or credited to a portion of your Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drug Products as set forth in The Schedule of Copayments may be reduced in order for Patient Assurance Program discounts earned by the Healthplan to be applied or credited to the Copayment or Coinsurance, if any, as described above.

For example, certain insulin product(s) covered under the Prescription Drug Benefit for which the Healthplan directly or indirectly earns a discount in connection with the Patient Assurance Program shall result in a credit toward some or all of your Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in The Schedule of Copayments, for the insulin product. In addition, the covered insulin products eligible for Patient Assurance Program discounts shall not be subject to the Deductible, if any.

Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum.

Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program does not count toward your Deductible and counts toward your Out-of-Pocket Maximum.

Please note that the Patient Assurance Program discounts that the Healthplan may earn for Prescription Drug Products, and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any rebates or other payments that the Healthplan may earn from a pharmaceutical manufacturer for the same or other Prescription Drug Products. Except as may be noted elsewhere in this plan, you are not entitled to the benefit of those rebates or other payments earned by the Healthplan because they are unrelated to the Patient Assurance Program. Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drug Products included in the Patient Assurance Program and/or your Copayment or Coinsurance, if any for those eligible Prescription Drug Products, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to the Healthplan in connection with the Patient Assurance Program. More information about the Patient Assurance Program including the Prescription Drug Products included in the program, is available at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Coupons, Incentives and Other Communications

At various times, the Healthplan or its designee may send mailings to you or your Dependents or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain

coupons or offers from pharmaceutical manufacturers that enable you or your Dependents, at your discretion, to purchase the described Prescription Drug Product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a particular medication is appropriate for your medical condition. The Healthplan and its affiliates are not responsible in any way for any decision you make in connection with any coupon, incentive, or other offer you may receive from a pharmaceutical manufacturer or Physician.

If Healthplan determines that a Pharmacy, pharmaceutical manufacturer or other third party is or has waived, reduced, or forgiven any portion of the charges and/or any portion of Copayment and/or Deductible amount(s) you are required to pay for a Prescription Drug Product without Healthplan's express consent, then Healthplan in its sole discretion shall have the right to deny the payment of benefits in connection with the Prescription Drug Product, or reduce the benefits in proportion to the amount of the Copayment and/or Deductible amounts waived, forgiven or reduced, regardless of whether the Pharmacy, pharmaceutical manufacturer or other third party represents that you remain responsible for any amounts that the Agreement does not cover. In the exercise of that discretion, Healthplan shall have the right to require you to provide proof sufficient to Healthplan that you have made your required cost share payment(s) prior to the payment of any benefits by the plan.

For example, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a Prescription Drug or Related Supply, Healthplan may, in its sole discretion, reduce the benefits in proportion to the amount of the Copayment and/or Deductible amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment and/or Deductible you are required to pay.

Please refer to Section III. for a description of Prescription Drug Limitations.

III. Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive thirty (30) day supply at a retail Participating Pharmacy and a ninety (90) day supply at a Designated 90 Day Retail Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive ninety (90) day supply at a mail order Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- a dosage and/or dispensing limit as determined by the P&T Committee.

Cigna 90 Now CVS Pharmacy Network

The Cigna 90 Now CVS pharmacy program is comprised of a 90-day prescription drug benefit and a retail pharmacy network that includes a network of Participating Pharmacies that are contracted to fill 30-day supplies of Prescription Drugs and Related Supplies to Members and a subset of retail Participating Pharmacies – which are called Designated 90 Day Retail Pharmacies in this Agreement - that are contracted to fill 90-day supplies of Prescription Drugs and Related Supplies to Members. Members may also fill 90-day prescriptions through the mail order Participating Pharmacy. Members can locate a Designated 90 Day Retail Pharmacy that participates in the Cigna 90 Now CVS network by contacting Cigna at the number on the back of their identification card or on myCigna.com. The retail copayment for a 90-day supply obtained at a Designated 90 Day Retail Pharmacy may be 2-3 times the 30-day retail copayment. This Copayment will be reflected in the Schedule.

Please refer to Section I. (Definition of "Prescription Drug List") for a description of Cigna HealthCare's Prior Authorization Process.

IV. Member Payments

Coverage for Prescription Drugs and Related Supplies is subject to a Copayment and Out-of-Pocket Maximum. In the event a Member's Copayment exceeds the retail cost of the Prescription Drug and/or Related Supplies the Member's Copayment will not exceed the pharmacy's usual and customary charge (also known as the "retail charge") for the Prescription Drug and/or Related Supplies.

- If two or more prescriptions or refills are dispensed at the same time, a Copayment must be paid for each prescription order or refill.
- When a treatment regimen contains more than one type of drug and the drugs are packaged together for the convenience of the Member, a Copayment will apply to each type of drug.

Under California law a pharmacist is permitted to dispense a partial fill of certain Schedule II controlled substances. When a partial fill of such a Schedule II controlled substance that is a covered prescription drug (oral, solid dosage form) is dispensed, the Member cost share for the partial fill will be prorated.

Please refer to the Prescription Drug Schedule of Copayments for the required Copayments and Out-of-Pocket Maximum.

Coverage will be provided for "generic" Prescription Drugs at the stated "generic" Copayment if they are Medically

Necessary as determined by the Healthplan Medical Director and not otherwise excluded under this Rider.

Coverage will be provided for Medically Necessary "name brand" Prescription Drug List drugs and non-Prescription Drug List drugs at the stated Copayment if they are Medically Necessary as determined by the Healthplan Medical Director and not otherwise excluded under this Rider.

V. Exclusions

Except as otherwise set forth in this Rider, coverage for Prescription Drugs and Related Supplies is subject to the exclusions and limitations set forth in the "Exclusions and Limitations" Section of the Agreement. In addition, any services or benefits related to Prescription Drugs and Related Supplies which are not described in this Supplemental Rider are excluded from coverage under the Agreement. By way of example, but not of limitation, the following are specifically excluded services and benefits:

1. Any drugs or medications available over the counter that do not require a prescription by federal or state law, and any drug or medication that has a chemical equivalent (i.e., same active ingredient and equivalent dosage) to an over the counter drug or medication other than insulin.
2. Any drugs that are experimental or investigational, within the meaning set forth in the Agreement.
3. Food and Drug Administration (FDA) approved prescription drugs used for purposes other than those approved by the FDA unless the drug is prescribed for the treatment of a life-threatening or chronic and seriously debilitating condition, the drug is Medically Necessary to treat that condition, and the drug has been recognized for treatment of that condition by one of the following: The American Medical Association Drug Evaluations; The American Hospital Formulary Service Drug Information; The United States Pharmacopeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional"; or two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence present in a major peer reviewed medical journal.
4. All newly FDA approved drugs, prior to review by the Pharmacy and Therapeutics committee unless deemed Medically Necessary by Healthplan Medical Director.
5. Any prescription and non-prescription supplies (such as ostomy supplies), devices, and appliances, except as covered in this Rider. Please refer to Definitions, Related Supplies, for covered supplies.
6. Any drugs used for treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.
7. Any prescription vitamins (other than prenatal vitamins), dietary supplements, and fluoride products.
8. Prescription drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products.
9. Any diet pills or appetite suppressants (anorectics) except when Medically Necessary for the treatment of morbid obesity.
10. Prescription smoking cessation products unless Medically Necessary.
11. Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
12. Replacement of Prescription Drugs due to loss or theft.
13. Drugs used to enhance athletic performance.
14. Drugs which are to be taken by or administered to a Member while the Member is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.
15. Prescriptions more than one year from the original date of issue.
16. Any infertility drugs or infertility injections.

Supplemental Rider

This Supplemental Rider is a part of the Medical Group Service Agreement ("the Agreement") and replaces the "Rehabilitative Therapy" benefits provided in the Agreement, and is subject to all the terms, conditions and limitations contained therein.

Rehabilitative Therapy

Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. This includes routine or long-term therapy provided to maintain current health status when it is medically necessary.

The following limitations and exclusions apply to Rehabilitative Therapy:

- For Rehabilitative Therapy, the Healthplan may request that your Participating Provider provide biweekly updates on your progress.

- Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living after an illness or injury.
- 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 diagnosed medical condition or injury are not covered unless determined to be Medically Necessary;
- Speech therapy or treatment for functional articulation disorder, such as correction of tongue thrust, lisp, stuttering, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury is not covered unless determined to be Medically Necessary; and
- Treatment consisting of routine or long-term therapy provided to maintain the patient's current health status is not covered unless determined to be Medically Necessary.

If any Rehabilitative Therapy has been denied on the basis of not being Medically Necessary, you may seek an appeal through the "Independent Medical Review for Experimental and Investigational Therapies and Disputed Health Care Services" under "Section III. Agreement Provisions".

Services that are provided by a chiropractic Physician are not covered. These services include the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

Outpatient Cardiac Rehabilitation Services

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

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

Supplemental Rider

This Supplemental Rider is a part of the Cigna HealthCare of California, Inc. Group Service Agreement ("the Agreement") and is subject to all of the terms, conditions and limitations contained therein. In consideration for an additional monthly fee incorporated into the Prepayment Fee, the following supplemental benefit for Domestic Partner Coverage is added to the "Eligibility" section of the Agreement as Item C.

Domestic Partner

C. To be eligible to enroll as a non-registered domestic partner, you must be a person of the same or opposite sex who:

1. shares a permanent residence with the Subscriber;
2. has resided with the Subscriber for not less than one year;
3. is at least eighteen (18) years of age;
4. be financially interdependent with the Subscriber and have proven such interdependence by providing documentation of at least two (2) of the following arrangements:
   a. common ownership of real property or a common leasehold interest in such property;
   b. common ownership of a motor vehicle;
   c. a joint bank account or a joint credit account;
   d. designation as a beneficiary for life insurance or retirement benefits or under the Subscriber's last will and testament;
   e. assignments of a durable power of attorney or health care power of attorney; or
   f. such other proof as is considered by Healthplan to be sufficient to establish financial interdependency under the circumstances of a particular case,
5. is not a blood relative any closer than would prohibit legal marriage, and
6. have signed jointly with the Subscriber, a notarized affidavit in form and content satisfactory to Healthplan and make this affidavit available to Healthplan.

You are not eligible to enroll as a domestic partner if either you or the Subscriber:

1. has previously filed a Declaration of Domestic Partnership with the Secretary of State pursuant to Division 2.5 of the Family Code that has not been terminated under Section 299 of the Family Code;
2. signed a domestic partner affidavit or declaration with any other person within twelve months prior to designating each other as domestic partners under this Agreement;
3. are currently legally married to another person; or have any other domestic partner, spouse or spouse equivalent of the same or opposite sex.

An eligible domestic partner's children who meet the Dependent eligibility requirements in "Section II. Enrollment and Effective Date of Coverage" are also eligible to enroll.

The "Continuation of Group Coverage under COBRA" section of this Agreement does not apply to the Subscriber's domestic partner and his/her Dependents. However, the "Continuation of Group Coverage under Cal-COBRA" section of this Agreement does apply to the Subscriber's domestic partner and his/her Dependents.

Supplemental Rider

This Supplemental Rider is a part of the Cigna HealthCare of California, Inc. Group Service Agreement ("the Agreement") and is subject to all of the terms, conditions and limitations contained therein. In consideration for an additional monthly fee incorporated into the Prepayment Fee, the following supplemental benefit for Hearing Aid Coverage is added to the "Covered Services and Supplies" section of the Agreement.

Hearing Aid Appliances

Purchase and fitting of hearing aid appliances are covered if ordered or prescribed by a Participating Physician, available only by prescription and are medically necessary for any of the following:

- conductive hearing loss unresponsive to medical or surgical interventions;
- sensorineural hearing loss;
- mixed hearing loss.

Hearing aids include but are not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.

ERISA Required Information

The name of the Plan is:

Quinn, Emanuel Urquhart & Sullivan, LLP

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

Quinn, Emanuel Urquhart & Sullivan, LLP
865 S. Figueroa St., 10th Floor
Los Angeles, California 90017
213-443-3837

Employer Identification Number (EIN)	Plan Number
954004138	501

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 the service of legal process is:

Employer named above (May be Plan trustee, if any; or Plan Administrator.)

The office designated to consider the appeal of denied claims is:

Cigna HealthCare of California, Inc.
National Appeal Unit
Post Office Box 2125
Glendale, CA 91209-2125

Healthplan toll free number is on your Cigna HealthCare ID card

The cost of the Plan is funded by contributions from the Employer and/or Members:

The Plan's fiscal year ends on 08/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request from the Plan Administrator.

Plan Type

The Plan is a healthcare benefit plan.

Collective Bargaining Agreement

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 the Healthplan 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 the Healthplan 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. 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, is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. 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 or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the last day of the calendar month in which you leave Active Service;
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute, or;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrators 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 Pension and Welfare Benefit 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 participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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, in whole or in part, 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. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents 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.

Enforce Your Rights

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.

Claim Determination Procedures Under ERISA

The following complies with federal law effective July 1, 2002. Provisions of the 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 either a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice medical necessity determination." The Agreement describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request medical necessity determinations according to the procedures described below, in the Agreement, and in your provider's network participation documents as applicable.

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

Preservice Medical Necessity Determinations

When you or your representative request a required medical necessity determination prior to care, the Healthplan shall 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 the Healthplan's control, the Healthplan 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 the Healthplan within 45 days after receiving the notice. The determination period will be suspended on the date the Healthplan 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 (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, the Healthplan will make the preservice determination on an expedited basis. the Healthplan Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. The Healthplan 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, the Healthplan 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 the Healthplan within 48 hours after receiving the notice. The Healthplan will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow the Healthplan's procedures for requesting a required preservice medical necessity determination, the Healthplan will notify you or your representative of the failure and describe the proper procedures for filing within five 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 Medical Necessity 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 medical necessity 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, the Healthplan will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

When you or your representative requests a medical necessity determination after services have been rendered, the Healthplan 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 the Healthplan's control the Healthplan 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 the Healthplan within 45 days after receiving the notice. The determination period will be suspended on the date the Healthplan 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: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

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. The Healthplan will provide administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration. Benefits provided under this Agreement are fully guaranteed by the Healthplan. This Agreement is issued by the Healthplan.