DLC NO. 0220-2023

VIRGIN ISLANDS DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

September 11, 2023

VIA SHAREPOINT©
Honorable Albert Bryan Jr.
Governor of the Virgin Islands
Government House
Nos. 21-22 Kongens Gade
St. Thomas, VI 00802

Attn: Richard T. Evangelista, Esq.
Chief Legal Counsel to the Governor

Re: IMPORTANT: The current Medical Insurance Agreement ends on September 30, 2023, and the attached Agreement requires the Governor's and the Legislature's approval.
Group Medical Health Insurance Agreement between the Government of the Virgin Islands, through the GESC/Health Insurance Board of Trustees, and ***Cigna Health and Life Insurance Company for Group Medical Health Insurance***
A.G.O. File No. K-23-0369

Dear Governor Bryan:

Transmitted herewith for your approval is the Agreement for Group Medical Health Insurance ("Medical Agreement") by and between the Government of the Virgin Islands, through the GESC/Health Insurance Board of Trustees ("Board")("Government"), and the Virgin Islands Port Authority (the "Authority"), the University of the Virgin Islands ("UVI"), the Virgin Islands Housing Authority (the "Housing Authority"), Non-Profit Organizations defined as eligible by the Government, and Frederiksted Health Care, Inc. ("FHC")(the Government, the Authority, UVI, East End Medical, the Housing Authority, Non-Profit Organizations and FHC hereinafter individually referred to as, each, "Employer Entity" and collectively referred to as the "Employer") and Cigna Health and Life Insurance Company (hereinafter "Cigna"). According to the terms of the Medical Agreement, Cigna will provide group health insurance coverage to active government employees, pre-65 retirees, and their dependents for a term commencing October 1, 2023, and ending September 30, 2024. The Government Employees Health Insurance Board prepared a

summary of the medical plans for 2023-2024 in a letter dated August 23, 2023 ("Board Letter"), which is attached for your review.

Under the Virgin Islands Code Title 3 V.I.C. §633, the Board must issue a Request for Proposal from companies interested in providing group medical insurance coverage for its employees at least once every five years. According to the Board Letter, the Board completed a Request for Proposals (RFP) for competitive bids as required by statute for insurance services, which included Medical and Prescription Drug coverage for active employees and retirees, Employee Assistance Program, Dental, Vision, Life, and Accidental Death & Dismemberment (AD&D) plans. The RFP was released on March 15, 2023, and bids were received through April 24, 2023. Advertisements were released nationally and in the St. Croix, St. John, and St. Thomas Source publications from March 15 through April 14, 2023.

Through the RFP process, the Board received two (2) responses for medical coverage covering all active employees and pre-65 retirees - One from Cigna Healthcare (incumbent) and one from UnitedHealthcare. UnitedHealthcare proposed a 2% increase in premiums while matching the existing benefits. Subsequently, Cigna offered a premium rate cap for year 2 of the Contract not to exceed 8%, while United provided a not-to-exceed of 12%. The RFP evaluations were reviewed at the Board's May meeting, and finalist meetings were held in person at the Board's meeting in June.

The Board Letter also explains that based upon the most recent medical claims experience report through July 2023, the medical claims expenditures are 90% of the medical plans' premiums, excluding other plan expenditures such as administrative costs. The medical claims expenditure has increased from the prior year. Although the losses have increased 4.4% from the prior period, the Board was anticipating a 5-8% increase in premiums to cover future claims and expenses based upon an analysis by our Consultant, Gehring Group.

Since the premiums will remain the same for the upcoming fiscal year, the overall impact on the Central Government will be approximately $107 million based on the existing cost-share with employees and retirees. It was vital to the Board that there were no plan design changes (i.e., increasing copayments, deductibles, out-of-pocket maximums) due to the current state of the economy, and Cigna agreed not to change any of the benefits, nor did they decrease the level of services that are offered with the current plan.

In addition to the above financial implications, Cigna will continue to include and enhance the following in their Contract with the Board:

- Support the USVI community by providing six (6) two-year nursing scholarships to the University of the Virgin Islands for $6,250 per student per year and providing $375,000 in grants to non-profit agencies;
- Provide a Wellness Funds of $1,000,000 (currently $700,000);
- Continuation of the two (2) full-time on-site Customer Service Representatives;

- Inclusion of MotivateMe, a turnkey wellness incentive program that gives employees and their spouses' opportunities to earn rewards for taking charge of and improving their health while funding $300,000 in incentives; Continuation of Omada's Pre-Diabetes Prevention Program;
- Continuation of Omada's Pre-Diabetes Prevention Program;
- Continuation of the 2 Health Improvement Offices with two (2) health coaches and two (2) mobile vans;
- Placing $1.7 in premiums at risk for performance guarantees; and
- The Cigna Foundation will be offering $250,000 in grants over the next three years to non-profits in the Territory, helping those living with obesity, high blood pressure, diabetes, and other chronic conditions to improve their overall health

The Office of Management and Budget includes the cost of health insurance in each department's budget for its employees' fringe benefits. This Contract is expressly made subject to your approval and the appropriation and availability of funds. The Contract includes language allowing for execution in any number of counterparts, each of which shall be deemed an original, even if a photocopy or facsimile. Therefore, the enclosed Contract has the original signature of the Cigna representatives and copies of the execution by the Employers involved in the Contract.

I have attached for your review the following documents:

1. Certificate of Authority (no business license is required because insurance companies are not engaged in any business, occupation, profession, or trade listed in 27 V.I.C. § 302);
2. Secretary's Certificate for signatory;
3. Renewal Evaluation;
4. GESC/Health Insurance Board of Trustees letter dated August 23, 2023;
5. GERS Group Health Projected Budget;
6. Open Access Plus Plan Benefit Summary;
7. Certificate of Redomestication;
8. Amended and Restated Articles of Incorporation; and
9. Medical Insurance Agreement.

Thank you for considering this matter. The Fourth Renewal and supporting documents have been reviewed and approved for legal sufficiency. If you have questions, please contact Assistant Attorney General Ian S.A. Clement, Esq., or me at 340-774-5666.

Sincerely,

Pamela R. Tepper
Solicitor General

Enclosures: Fourth Renewal and Supporting Documents

cc: Ariel M. Smith, Esq., Attorney General
Department of Justice

Beverly Joseph, Chairperson
GESC Health Insurance Board

Valerie P. Daley, Chief Health Insurance
Division of Personnel

AGREEMENT

FOR GROUP MEDICAL HEALTH INSURANCE

THIS AGREEMENT made and entered into this 1st day of October, 2023 by and between the Government of the Virgin Islands, through the Health Insurance Board of Trustees, (the "Government") the Virgin Islands Port Authority (the "Authority"), the University of the Virgin Islands ("UVI"), the Virgin Islands Housing Authority (the "Housing Authority"), Non-Profit Organizations defined as eligible by the Government, and Frederiksted Health Care, Inc. ("FHC") (the Government, the Authority, UVI, East End Medical, the Housing Authority, Non-Profit Organizations and FHC hereinafter individually referred to as, each, "Employer Entity" and collectively referred to as the "Employer") and Cigna Health and Life Insurance Company (hereinafter "Cigna"). For purposes of this Agreement, a Non-Profit Organization is an entity determined by the Government to satisfy the requirements under applicable U. S. Virgin Islands law for participation under this Agreement.

WITNESSETH:

WHEREAS, the Employer consists of the Government of the Virgin Islands and its independent instrumentalities; and

WHEREAS, the Employer provides group health insurance benefits to its eligible employees and their dependents, pre-65 retirees and their dependents, and under 65 dependents of retirees 65 and over (hereinafter the "Government Plan"); and

WHEREAS, in accordance with Title 3, Chapter 25, Subchapter VIII, of the Virgin Islands Code, the Employer issued a Request for Proposal No. 2023-01 from companies interested in providing group health insurance coverage for its employees; and

WHEREAS, Cigna along with other companies submitted a proposal to provide health insurance benefits to the Employer; and

WHEREAS, the Employer has accepted the proposal of Cigna and the parties have negotiated and arrived at an agreement for the terms of the contract; and

WHEREAS, the terms of the Group Medical Health Insurance Agreement shall consist of the terms provided herein and the terms of the addenda and attached exhibits which are fully incorporated herein by reference; and

NOW THEREFORE, for and in consideration of the mutual covenants and promises

Contractor's Initials Y.S.

made herein, the parties agree as follows:

1. TERM

This Contract shall be in force and effect for a term of twelve (12) months beginning on October 1, 2023, and ending September 30, 2024. This contract is subject to annual review and renewal, with terms to be renegotiated by the parties, for up to four (4) successive twelve (12) month terms. The Employer shall give notice of its intent to renew the contract at least sixty (60) days prior to the expiration of the term of the contract.

2. COMPENSATION FOR INSURER

A. The Employer shall pay premium payments to Cigna in accordance with the terms contained in Addenda I and II to the Contract which by this reference are incorporated herein.

B. Premium payments are due as provided for in Addendum 1. Cigna may terminate the insurance policy for the reasons set forth in Section 19 of this contract, including for non-payment of premium. It is understood by Cigna that the applicable Employer Entities, including the Housing Authority, the Non-Profit Organizations, the Authority, East End Medical, FHC and UVI shall be responsible for paying the premiums for its employees separate from the responsibility of the Government. If any paying entity shall default on the payment of premiums, Cigna may terminate the agreement with such entity.

C. While the future premiums shall be based upon the claims experience, it is agreed by the parties that the premium rates for any renewal period shall be calculated in accordance with Cigna's standard underwriting policies and procedures then in effect.

3. PREMIUM STABILIZATION RESERVE

A Premium Stabilization Reserve (PSR) will be established. The PSR will be funded from policy year to policy year with any experience-rating credits (premiums paid minus claims paid, reserve adjustments and expenses including risk charge) that develop in accordance with the Policy. Such funds are those which, under Cigna's standard underwriting policies and procedures, may otherwise be returned directly to the Employer. The PSR will be held by Cigna in conjunction with the Policy and will be apart from the reserves funded and maintained

Contractor's Initials Y.S.

by Cigna pursuant to applicable insurance law and sound underwriting practice. The funds in the PSR shall be held on behalf of Employer. All funds, including interest earned, will be paid to Employer on request, subject to the conditions contained herein, although such interest income, at the prospective rate set annually by Cigna for all PSRs, attributable to the PSR will be used by Cigna to offset expenses on the Policy. While all premiums earned by Cigna shall be due to Cigna regardless of the existence of the PSR, the PSR may be used to pay earned premiums only upon mutual agreement by and between Employer and Cigna.

The PSR will be debited for:

(a) the excess in any policy year of claims paid, reserve adjustments and expenses, including risk charge, over premiums earned (unless Employer chooses to pay Cigna part or all of such excess from other sources);

(b) any portion to be used at Employer's direction to reduce premium increases that may otherwise be charged, if approved by Cigna; and

(c) any portion to be used at Employer's direction to pay earned premiums, if approved by Cigna (Premium Holiday).

Upon termination of this Contract, any balance remaining in the PSR after being debited as set forth above will be paid to Employer, with interest, not later than 210 days after termination. In accordance with applicable Internal Revenue Service rulings, no withdrawals of funds from the PSR are permitted except as hereinbefore provided.

4. BENEFITS PLAN

The benefits provided to employees by Cigna are as described in Addendum 2 to the Contract and are incorporated herein.

5. PARTICIPATING PROVIDER DIRECTORY

Participating Provider Directories are available on mycigna.com or viequicare.com.

6. OPEN ACCESS PLAN

(a) The Plan under this Contract (for all except Puerto Rico residents), shall be part of Cigna's Open Access Plan ("OAP'). Under the OAP, members have the opportunity to select a

Contractor's Initials Y.S.

Primary Care Physician ("PCP"). However, this is not a requirement and the decision is made at the member level when they enroll in the plan. Although members are not required to choose a PCP under the OAP, split co-pay differentials between the PCPs and specialists may result. The lower co-pays for PCPs provide an incentive to members to seek care in the most appropriate, cost effective setting.

(b) The OAP shall apply to members obtaining medical services on the mainland United States. Members who are residents of the Virgin Islands shall remain part of a Participating Provider network utilized for medical services obtained in the Virgin Islands and in Puerto Rico. The Employer's group medical plan shall be considered an OAP. For Puerto Rico residents the plan shall be an indemnity plan.

7. BOOKLETS

Within SIXTY (60) days of final approval of this agreement and of the benefit plan to be provided to Employer, Cigna shall produce and distribute the complete booklet describing the agreed upon benefit plan. This benefit plan booklet will include a Summary of Benefits and Coverage that shall meet the requirements set forth in PPACA. The number of copies and manner of distribution will be as directed by the Employer and as agreed upon by and between the Employer and Cigna.

8. REPORTS

A. Cigna shall provide Employer with the following standard reports as follows:

(a) Detail claim register, noting claims paid	(Upon Request)
(b) Premium earned vs. claims paid report	(Monthly)
(c) Large claims report year-to-date claim	(Monthly)
(d) Financial year end accounting	(Annual)
(e) On/Off island report	(Quarterly)
(f) Quality accuracy reporting	(Quarterly)
(g) Experience and Utilization Analysis reports	(Annually)
(h) Monthly enrollment totals	(Quarterly)

Contractor's Initials Y.S.

(i) Detailed Utilization analysis including by service/treatment type plus comparisons to Book of Business norms (Annually)

Each of the above listed reports shall provide information separately by:

1. Status (i.e., Member or Dependent)

2. Class of Participant (i.e., Active or Pre-65 Retiree)

3. Employer Entity (i.e., Government, UVI, the Authority, Non-Profit Organization, etc.)

B. In addition to standard reports (currently listed in the contract), any non-standard ad hoc reports shall be produced at charges to be determined by Cigna.

9. ENROLLMENT

Cigna shall accept and provide coverage for all of the present active employee and Pre-65 retiree enrollees without requiring evidence of insurability.

10. PERFORMANCE GUARANTEES

Cigna and Employer have agreed upon certain performance guarantees as set forth below. Failure to satisfy any of the performance guarantees shall not, by itself, constitute a material breach of this Agreement as long as Cigna's performance under the performance guarantees set forth below does not fall below 80% for any measurable standard for two consecutive reporting periods.

The performance guarantees set forth below are effective as of October 1, 2023 (the "Commencement Date"). The "Term" of the performance guarantees shall be from the Commencement Date through the last day of the twelfth (12th) consecutive month following the Commencement Date (the "Term").

Performance Commitments and Penalty Amounts

In connection with the services Cigna will provide to the Employer with respect to the Plan, Cigna guarantees its performance as stated below. (A summary of all performance commitments and their associated penalties is attached hereto and made a part hereof at Addendum 3).

Contractor's Initials Y.S.

A. Time to Process

1. Time-to-Process Performance Commitments

(a) 14 Day Time-to-Process Performance Commitment. Cigna shall process a designated percentage of claims it receives in connection with the Plan during the Term ("Claims") within fourteen (14) Calendar Days, as calculated under the lime-to-Process Formula set forth below. The designated percentage is shown in Addendum 3 of this Agreement.

(b) 30 Day Time-to-Process Performance Commitment. Cigna shall process a designated percentage of Claims within thirty (30) Calendar Days, as calculated under the Time-to-Process Formula set forth below. The designated percentage is shown in Addendum 3 of this Agreement.

2. Time-to-Process Results Measurement

(a) The calculation of the time to process Claims ("Time-to-Process") will be account-specific.

(b) Time-to-Process will be calculated by counting the number of Calendar Days from the Calendar Day that the Claim is received by Cigna to and including the Calendar Day the Claim is processed. The Calendar Day the Claim is received will not be included in this calculation.

(c) "Calendar Days" will mean the days of the week, including Saturdays, Sundays and all holidays.

Contractor's Initials Y.S.

3. Time-to-Process Penalties

(a) 14 Day Time-to-Process Penalty. The penalty for Cigna's failure to meet the 14 Day Time-to-Process Performance Commitment shall be the amount shown in Addendum 3 of this Agreement.

(b) 30 Day Time-to-Process Penalty. The penalty for Cigna's failure to meet the 30 Day Time-to-Process Performance Commitment shall be the amount shown in Addendum 3 of this Agreement.

B. Financial Accuracy

1. Financial Accuracy Performance Commitment. The claim offices servicing the Employer (the "Claim Offices") shall correctly pay a designated percentage of the total Claim dollars paid for all accounts serviced by the Claim Offices during the Term. The designated percentage is shown in Addendum 3 of this Agreement.

2. Evaluation of Financial Accuracy. Fulfillment of the Financial Accuracy Performance Commitment set forth above ("Financial Accuracy") will be determined as follows:

   (a) Data used to determine Financial Accuracy will be comprised of the claims audited for all accounts in the course of routine claim audits conducted by each Claim Office during the Term.

   (b) Financial Accuracy will be measured by subtracting the sum of the total dollars overpaid and the total dollars underpaid (without offsetting one against the other) from the total dollars paid and dividing that amount by the total dollars paid.

3. Financial Accuracy Penalty. The penalty for Cigna's failure to meet the Financial Accuracy Performance Commitment shall be the amount shown in Addendum 3 of this Agreement.

Contractor's Initials Y.S.

C. Claim Payment Accuracy

1. Claim Payment Accuracy Performance Commitment.

The claim offices servicing the Employer (the "Claim Offices") shall accurately pay (correct dollar amount) a designated percentage of the total claims paid for all accounts serviced by the Claim Offices during the Term. The designated percentage is shown in Addendum 3 of this Agreement.

2. Evaluation of Claim Payment Accuracy.

Fulfillment of the Claim Payment Accuracy Performance Commitment set forth above ("Claim Payment Accuracy") will be determined as follows:

(a) Claim Payment Accuracy will be measured by dividing the number of claims accurately paid by the number of claims audited.

(b) Data used to determine Claim Payment Accuracy will be comprised of the claims audited for all accounts in the course of routine claim audits conducted by each Claim Office during the Term. The Claim Office results will be weighted in accordance with Section 10.F.1 below.

3. Claim Payment Accuracy Penalty.

The penalty for Cigna's failure to meet the Claim Payment Accuracy Performance Commitment shall be the amount shown in Addendum 3 of this Agreement.

D. Telephone Services

1. Telephone Services Performance Commitments.

Cigna makes the following commitments with respect to its customer service call or claim centers servicing the Employer ("Call Centers"):

(a) Average Speed of Answer Commitment. The average speed to answer a phone call to a Call Center during the Term ("ASA") shall be no longer than the number of seconds designated in Addendum 3 of this Agreement.

(b) Telephone Abandonment Commitment. The percentage of calls received by the Call Center resulting in the caller terminating the

Contractor's Initials Y.S.

call before speaking with a customer service representative (the "Abandonment Rate") shall, on average, be no greater than the percentage designated in Addendum 3 of this Agreement.

2. Evaluation of ASA and Abandonment Rate.

(a) The ASA will be determined by measuring the sum of the total elapsed time between the moment when telephone callers to Call Centers select to speak with a customer service representative and the time the callers are connected with a customer service representative, and dividing that number by the total number of telephone calls answered by the Call Centers during the Term.

(b) Abandonment Rate will be measured by dividing the total number of calls received by each Call Center during the Term that result in the caller terminating the call before

speaking to a customer service representative by the total number of telephone calls received by the Call Centers during the Term and expressing that number as a percent.

(c) ASA and Abandonment Rate will each be calculated automatically by the automatic telephone call distribution system used by each Call Center.

(d) The calculation of ASA and Abandonment Rate will be based on all telephone calls answered or received by the Call Centers and not solely on telephone calls relating to

services provided by Cigna to the Plan.

3. Telephone Services Penalties

(a) Telephone Average Speed to Answer Penalty. The penalty for Cigna's failure to meet the Telephone Average Speed to Answer Performance Commitment shall be the amount shown in Addendum 3 of this Agreement.

(b) Telephone Abandonment Penalty. The penalty for Cigna's failure to meet the Telephone Abandonment Performance

Contractor's Initials Y.S.

Commitment shall be the amount shown in Addendum 3 of this Agreement.

E. Account Management

1. Account Management Commitment

Cigna's Account Management Team commits to provide services to the Employer of such quality as will result in Cigna's achieving the Account Management Composite Score on the Account Management Report Card. The Account Management Report Card is attached to Addendum 3 of this Agreement and will be completed by the Employer on a quarterly basis.

2. Evaluation of Account Management.

(a) At the beginning of the Term, the Employer shall designate individuals on its benefits staff who will receive and complete the Account Management Report Card on a quarterly basis.

(b) The Account Management Report Card will be distributed to the Employer's designated staff members on a quarterly basis and shall be completed and returned to Cigna by the Employer within three weeks of its distribution date. The failure of the Employer to satisfy this condition shall nullify the Account Management Commitment.

(c) Following the end of the Term and receipt of the 4th quarterly survey from the Employer. Cigna will calculate the Composite Score in each performance assessment category by averaging the scores for the four quarters of the Term. The assessments of each of the designated staff members and each of the performance assessment categories will be weighted equally. The Account Management Commitment will be deemed as fulfilled if the average of the Composite Scores in each category (the "Account Management Composite Score") is equal to or greater than the Account Management Composite Score indicated on Exhibit A to Addendum 3 of this Agreement.

(d) Cigna reserves the right to make changes in the staff/personnel assigned to an account during the Term.

Contractor's Initials Y.S.

3. Account Management Penalty.

The penalty for Cigna's failure to meet the Account Management Commitment shall be the amount shown in Addendum 3 of this Agreement.

F. Weighting of Performance Results

1. Weighting of Results for Financial Accuracy and Claim Payment Accuracy.

Results for Financial Accuracy and Claim Payment Accuracy will be weighted to accurately reflect the proportion of Claims processed in each Claim Office on behalf of the Plan. Specifically, the results for each Claim Office during the Term will be multiplied by a fraction where the numerator is equal to the number of Claims processed in each Claim Office on behalf of the Plan and the denominator is equal to the total claims processed in all Claim Offices for the Plan. The resulting product for each Claim Office will be added together, and the sum will represent the "Weighted Result." The Weighted Result will determine whether the performance commitment has been met.

2. Weighting of Results for Telephone Services.

Results for Telephone Services from each assigned Inquiry Center will be weighted equally in order to calculate the overall result.

G. Evaluation of Services and Payment of Penalties

1.Within four months after the end of the Term, Cigna shall compile the necessary documentation and perform the necessary calculations to evaluate its fulfillment of each performance commitment set forth in this Agreement and make this information available to the Employer.

2. Any dispute with the amount Cigna determines to be owed under this Agreement must be raised in writing within sixty (60) days of the date that Cigna notifies the Employer in writing of its determination.

3. If Cigna fails to meet any of the performance commitments set forth above, Cigna shall pay to the Employer the appropriate financial penalty set forth in Addendum 3 of this Agreement.

Contractor's Initials Y.S.

4. The penalty amounts in Addendum 3 have been established in relationship to the number of employees that the Employer has projected will be enrolled on the Effective Date. That number is stated in Addendum 3. In the event that the actual number of employees enrolled on the Effective Date is greater than one hundred fifteen percent (115%) of the projected number, the Employer reserves the right to increase the penalty amounts in proportion to the variation between the actual and projected number of enrolled employees. Correspondingly, Cigna reserves the right to decrease the penalty amounts in proportion to the variation between the actual and projected number of enrolled employees in the event that the actual number of employees enrolled on the Effective Date is less than eighty-five (85%) of the projected number.

5. The total amount payable by Cigna during the Term for failure to meet the performance commitments set forth in this Agreement shall not exceed the sum of the penalties associated with each performance commitment, that total amount being $1,268,100.

6. Change in Reporting Format or Measurement. Cigna reserves the right to replace or modify any performance commitment if necessitated by a change in circumstances that would cause the performance commitment to be an inaccurate or unfair method of measuring Cigna's performance. In such event, the performance commitment will be modified to the degree necessary to carry out the intent of the parties.

7. Setoff. Cigna shall be entitled to setoff any amount owed by Cigna to the Employer under this Agreement against any debt owed by the Employer to Cigna, whether now existing or hereafter arising.

H. Force Majeure

Notwithstanding any other Force Majeure clauses in this Agreement, and as more fully set forth in Addendum 4, Cigna shall not be liable for any failure to meet any of the obligations specified or required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of Cigna, its employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or reasonably controlled by Cigna, its employees, officers, or directors, acts of God, fires, wars, accidents, labor

Contractor's Initials YS

disputes or shortages. and governmental laws, ordinances, rules or regulations, whether valid or invalid.

I. Termination of Performance Guarantee Agreement

The provisions of this Article and Addendum 3 to this Agreement with respect to Performance Guarantees shall terminate upon the earliest of the following dates:

1. the end of the Term;

2. the effective date of any state's or other jurisdiction's action which prohibits activities of the parties under this Agreement;

3. the date upon which the Employer fails to pay any premium charges, fees or other charges within the time frame specified in the applicable contract;

4. the date upon which the contract under which Cigna provides services to the Employer is terminated;

5. any other date mutually agreeable to the Employer and Cigna.

11. LOCAL CUSTOMER REPRESENTATIVES

See Addendum 5 attached hereto and made a part hereof.

12. WELLNESS STRATEGIES

Cigna will work with the Government of the Virgin Islands GESC/Health Insurance Board of Trustees ("GESC Board") to develop and execute a Wellness Strategy.

To support this Strategy Cigna shall:

A. Health Improvement Fund.

Provide annual funding in the amount of One Million nd 00/100 dollars ($1,000,000.00) to be utilized prior to September 30, 2024, for mutually agreed upon wellness initiatives focused on improving health status and awareness for Government Employees and their Dependents as more fully explained in Addendum 10 attached hereto and made a part hereof. A separate funding will be provided towards administration of the MotivateMe program in the amount of Three Hundred Thousand and 00/100 dollars ($300,000). As set forth in Addendum 10, unused funds shall not be carried over beyond October 1, 2024 ; and

Contractor's Initials Y.S.

B. Health Improvement Centers

Provide as contained in Addendum 9 to the Contract and by this reference are incorporated herein; and

C. Nursing Scholarships

Endow two-year scholarships to the University of the Virgin Islands Nursing School for qualified Territory residents at a level of $6,250 per student per year. Cigna shall endow a maximum of six such scholarships for a maximum combined value of $75,000 over five years provided that this Agreement is renewed for additional terms. Cigna shall endow no more than two such scholarships during any twelve (12) month period under the Agreement. In return those students will agree to commit to work in the Territory for two years after graduation with a preference for working in the Health Improvement Centers.

13. APPROVAL and CONTRACT EFFECTIVE DATE

This Agreement is subject to and shall become effective upon the approval of the Governor of the Virgin Islands and the Legislature of the Virgin Islands.

14. TAXES and LICENSURE

Cigna shall maintain the appropriate licenses to conduct business in the Virgin Islands and shall pay all fees and taxes imposed by the Federal and Territorial government agencies, for its operations in the Virgin Islands. Cigna shall also comply with all local and federal laws and rules and regulations applicable to and pertaining to insurance and insurance transactions in the Virgin Islands.

15. LIABILITY OF OTHERS

Nothing in this Contract shall be construed to impose any liability upon the Employer by persons, firms, associations, or corporations engaged by Cigna as servants, agents, independent contractors, or in any other capacity whatsoever, or make the Employer liable to any such persons, firms, associations or corporations for the acts, omissions, responsibilities, obligations and taxes of Cigna of whatsoever nature, including but not limited to unemployment insurance and social security taxes for Cigna, its servants, agents or independent contractors.

16. ASSIGNMENT

(a) Assignment. Cigna shall not assign any rights under this Contract without the prior written approval of Employer.

Contractor's Initials Y.S.

(b) Delegation. Nothing set forth herein, however, shall preclude Cigna from assigning or subcontracting to its subsidiaries and affiliates any of its obligations due and owing to the Employer. Moreover, nothing herein shall preclude Cigna from assigning or subcontracting any obligations to any entity currently performing services for Cigna. Any such subcontracting or assignment shall not relieve Cigna of the ultimate responsibility for the performance of the Agreement.

(c) The Employer shall not assign any part of the services under this contract to any instrumentalities or agencies not specifically named in this document without the prior written approval of Cigna, which approval shall not be unreasonably withheld.

17. INDEMNIFICATION

Cigna agrees to indemnify, defend and hold harmless the Employer from and against any and all loss, damage, liability, claims, demands, detriments, cost charges and expenses (including attorney's fees) and causes of action of whatsoever character which the Employer may incur, sustain or be subjected to, arising out of or in any way connected to the services to be performed by Cigna, its affiliates, subcontractors or agents under this contract and arising from any cause, except the sole negligence of the Employer.

18. INDEPENDENT CONTRACTOR

Cigna shall perform this Contract as an independent contractor and nothing herein contained shall be construed to be inconsistent with this relationship or status.

19. TERMINATION

A. This Contract may be terminated only as follows:

1. By mutual agreement of the parties.

2. By the Employer, if it deems that it is in its best interest to do so. The Employer shall give Cigna THIRTY (30) DAYS written notice of its intent to terminate the Contract under this paragraph. In the event of termination under this paragraph, the Employer shall be liable for premium payments up to and including the date of termination.

3. By the Employer in the event of a material breach of the Contract by Cigna. For purposes of the paragraph, a material breach is a violation or nonperformance of a Contract term that is substantial and significant, may result in a liability to the

Contractor's Initials Y.S.

Employer, or may give rise to a cause of action against Cigna by Employer. the Employer shall give Cigna written notice of its intention to terminate ("Notice of Intent") the Contract pursuant to this Article, which Notice of Intent shall specify the duties and responsibilities that Cigna has failed to perform. Thereupon, Cigna shall have a period of THIRTY (30) DAYS following receipt of said Notice of Intent to cure such failure or failures. If Cigna cures such failure or failures in conformance with the requirements of the Contract and within said 30-day period, the Notice of Intent shall be deemed rescinded. If, however, Cigna fails to cure such failure or failures within said 30-day period, this Contract shall terminate upon the lapse of the 30-day period, unless the parties shall otherwise agree in writing. In the event of termination under this paragraph, the Employer shall be entitled to compensation for all liabilities resulting from the material breach causing termination.

4. By Cigna in the event of a material breach of the Contract by the Employer. For purposes of the paragraph, a material breach is a violation or nonperformance of a Contract term that is substantial and significant or that may give rise to a cause of action against the Employer by Cigna. Cigna shall give the Employer written notice of its intention to terminate the Contract pursuant to this paragraph ("Notice of Intent"), which Notice of Intent shall specify the duties and responsibilities that Employer has failed to perform or the reasons that led Cigna to the conclusion to terminate.

Thereupon, Employer shall have a period of THIRTY (30) DAYS following receipt of said Notice of Intent to cure such failure or failures. If Employer cures such failure or failures in conformance with the requirements of the Contract and within said 30-day period, the Notice of Intent shall be deemed rescinded. If, however, Employer fails to cure such failure or failures within said 30-day period, this Contract shall terminate upon the lapse of the 30-day period, unless the parties shall otherwise agree in writing.

In the event of termination under this paragraph, Cigna shall be entitled to premium payments up to and including the date of termination.

5. Termination in the event of non-payment of premium will be governed by Addendum I attached hereto.

B. Notice of termination shall be given a party by certified mail with return receipt requested addressed to the other party as provided in Section 33 of this Contract, and shall specify with particularity the nature and date of the termination.

C. In the event of termination of this Contract, the Employer has the sole responsibility to notify all Subscribers, as defined in Addendum 1 attached hereto, of the termination.

Contractor's Initials Y.S.

D. In the event of termination the Employer has the sole responsibility to fulfill requirements (if any) of notifying members of any state or federal conversion or continuation of coverage rights or benefits to which members might he entitled. Cigna has no responsibilities. liabilities, or duties related to this notification.

E. If in Cigna's discretion, it is in the best interests of Cigna for Cigna to additionally notify some or all Subscribers, as defined in Addendum 1 attached hereto, of termination of this Agreement, Cigna may do so, but in so doing does not lessen or relieve the obligations of the Employer stated in this paragraph. A copy of any notice intended to be sent to all or a significant portion of Subscribers, as defined in Addendum I attached hereto, shall be provided in advance of mailing to the Employer, except that prior notice is not required for notices that may be delivered electronically in response to electronic processing of claims or via phone in response to inquiries.

F. Notwithstanding anything herein to the contrary, in the event this Contract is terminated, Cigna shall continue to process claims incurred while the Contract was in effect so long as such claims are filed within the Run-Off Period, as that term is defined in Addendum 1.

20. GOVERNING LAW

A. This Contract shall be governed by the laws of the United States Virgin Islands and jurisdiction over any matter or dispute with respect to this Contract is exclusive in the courts, sitting in the U.S. Virgin Islands.

B. Cigna covenants that it has familiarized itself with the applicable provisions of Title 22, Virgin Islands Code.

21. WAIVERS AND AMENDMENTS

No waiver, modification or amendment of any term, condition or provision of this Contract shall be valid or of any force or effect unless made in writing, signed by the parties hereto or their duly authorized representative, and specifying with particularity the nature and extent of such waiver, modification or amendment. Any such waiver, modification or amendment in any instance or instances shall in no event be construed to be a general waiver, modification or amendment of any of the terms, conditions or provisions of this Contract, but the same shall be strictly limited and restricted to the extent and occasion specified in such signed writing or writings.

Contractor's Initials Y.S.

22. AUTHORITY

Each party warrants and represents that it is authorized to enter into this Agreement, and agrees to be bound by the terms herein. The parties further warrant and represent that the persons signing on their behalf are representatives of the entity with proper and sufficient authority to bind the entity to the terms of this Agreement.

23. RETENTION OF RECORDS AND ACCESS BY GOVERNMENT AGENCIES

Cigna, including its employees and subcontractors, shall maintain all claim records and supporting documentation books, accounting records and other evidence pertaining to costs expended or incurred under this Contract and make such materials available at their respective offices at all reasonable times, for inspection by authorized officials of the United States Virgin Islands, and concerned Federal agencies who are legally authorized to review such records. Each subcontract shall include a provision containing the conditions of this Section. This documentation described in this Section shall be retained and preserved for a period of SIX (6) years from the date of expiration or termination of this Contract.

24. RIGHT TO RECOVER

Cigna shall be financially responsible for any overpayment due to its own error. Any such overpayments that are recovered shall be credited to the claim experience of the plan(s) that Cigna insures for the Employer. Further, Cigna shall not, as a result of any such overpayment, charge Employer any amount in addition to the agreed upon premium rates.

25. Cigna PERSONNEL

Cigna shall commit a cohesive, dedicated, highly trained skilled core team to the management and administration of the Government Plan (said team hereinafter referred to as the "Government Plan Management Team"). Cigna shall also assign an account representative, who shall be a member of said core team, to the Government Plan who shall be available as needed to respond to inquiries from the GESC Board and the Office of Group Health Insurance. Cigna shall provide Employer with the names of the individuals constituting the Government Plan Management Team and a brief summary of the qualifications and professional experience of such individuals. Cigna shall advise the Government of any change in the composition of the Government Plan Management Team.

Contractor's Initials Y.S.

26. RECOVERY SERVICES

A. Definitions.

1. "Overpayments" means payments that exceed the amount payable under the plan (e.g. because of Health Care Provider billing error, retroactive or inaccurate eligibility information, coordination of benefits, Medicare disputes, or missing information), and other overcharges made by Health Care Providers, including, without limitation, overcharges discovered during the course of a hospital bill audit, and fraudulent claims.

2. "Health Care Provider" shall have the meaning set forth in Section 1722 of Title 22, Virgin Islands Code, as the same may be amended from time to time.

B. Coordination of Benefits and Subrogation.

Cigna has reasonable business processes for adjudicating claims submitted by covered individuals and providers for benefits provided to participants under Employer's group health insurance policy. The processes include coordinating benefits with other benefit plans that also provide coverage to individuals covered by Employer's group health policy and circumstances where a third party may be responsible for the cost of services provided. This process is integral to the administration of the policy and consequently there is no additional charge to Employer in addition to premium paid for the benefits provided under Employer's group health policy.

C. Claim Recovery.

As part of its normal operations, Cigna has reasonable processes for identifying and recovering Overpayments of its funds to third parties and such processes continue even after termination of the policy under which the claim payment may have been made. Decisions with respect to how to pursue recovery of such Overpayments are made by Cigna based on its judgment as to what steps are reasonable under the circumstances. Recoveries are made by Cigna for its own benefit with respect to benefit plans that it insures for such Employer and for the benefit of its self-insured clients. This process is integral to the administration of the Employer's policy and consequently there is no additional charge to Employer in addition to premium paid for the benefits provided under Employer's group health policy. Semiannually, Cigna shall furnish to Employer at no additional cost a list of Health Care Providers that have received Overpayments and with respect to whom after a period of 90 days from Cigna's discovery of the Overpayment, Cigna has been unable to collect the Overpayment. The list shall include the name of the Health Care Provider, a contact person, and the amount of the Overpayment. In the event that Employer takes action to

Contractor's Initials Y.S.

encourage or require the provider to return the overpayment, the overpayment must be returned to Cigna.

D. Abuse and Fraud.

As part of its normal operations, Cigna has reasonable processes for identifying situations where third parties, primarily plan participants and health care providers, may have received amounts to which they are not entitled based on the submission of false or inaccurate claims and for recovering its funds that it may have overpaid based on such claims. Such processes continue even after termination of the policy under which the claim payment may have been made. Decisions with respect to how to pursue such recoveries are made by Cigna based on its judgment as to what steps are reasonable under the circumstances. Recoveries are made by Cigna for its own benefit with respect to benefit plans that it insures and for the benefit of its self-insured clients. Often recoveries are conditioned on the execution of settlement releases that contain confidentiality provisions that prevent Cigna from disclosing the terms of such settlements except as required by law or court order. In the event that the disclosure of such settlement agreement provisions are requested pursuant to legal authority or court order, Cigna shall have the right to receive notice of the legal authority or court order compelling disclosure of such provisions. Cigna shall have the right to challenge any demand made by court order or by the authority of law for disclosure of the provisions of any settlement agreement that, by the terms of the agreement, are confidential. This process is integral to the administration of the policy and consequently there is no additional charge to Employer in addition to premium paid for the benefits provided under Employer's group health Policy.

27. IDENTIFICATION OF PROVIDERS AND PLAN PARTICIPANTS

When applicable and at no additional cost, Cigna will identify to Employer, providers of services or plan participants under review by Cigna's special investigations unit, from which review appears to be substantiated and that includes a significant number of claims for services relating to participants in Employer's health benefit plan. Such information shall include the focus of the review (e.g., upcoding, billing for services not rendered, billing more units of service than were actually provided), specifics of the claims under review and any results specific to claims submitted for payment under Employer's plan. Cigna will not supply information relative to claims for customers other than Employer except in response to a lawfully issued subpoena issued by the Government of the United States Virgin Islands (the "Government"). The Government may enforce its laws with respect to such claims notwithstanding any Provider Settlement that may have been negotiated by Cigna. In the event that the Government takes an

Contractor's Initials Y.S.

action with respect to claims paid by Cigna with respect to Employer's plan, Cigna shall be identified as the direct victim and shall be the party entitled to repayment or restitution of any overpayments, however denominated. Should the Government initiate any enforcement or criminal actions with respect to such claims, because claims were paid by Cigna, Cigna will be the party entitled to any refund or restitution however denominated.

28. CONDITION PRECEDENT

This Contract shall be subject to the availability and appropriation of funds and to the approval of the Governor. In addition, this Contract is subject to the approval of the Virgin Islands Legislature.

29. NON-DISCRIMINATION

No person shall be excluded from participating in, be denied the proceeds of; or be subject to discrimination in the performance of this Contract on account of race, creed, color, sex, religion, national origin or disability.

30. CONFLICT OF INTEREST

Cigna covenants that it is:

(1) Not a territorial officer or employee (i.e., the Governor, Lieutenant Governor, member of the Legislature or any other elected territorial official; or an officer or employee of the legislative, executive or judicial branch of the Government or any agency, board, commission or independent instrumentality of the Government, whether compensation on a salary, fee or other contractual basis); or

(2) a territorial officer or employee and, as such, has:

(i) familiarized itself with the provisions of Title 3, Chapter 37, Virgin Islands Code, pertaining to conflicts of interest, including the penalties provision set forth in section 1108 thereof;

(ii) not made, negotiated or influenced this contract, in its official capacity;

(iii) no financial interest in the contract as that term is defined in section 1101, (1) of said Code chapter.

Contractor's Initials Y.S.

31. CONTINGENT FEE PROHIBITED

Cigna warrants that it has not employed or retained any individual, corporation, partnership or other entity, other than a bona fide employee or agent working for Contractor to solicit or secure this Contract, and that it has not paid or agreed to pay any individual, corporation, partnership or other entity, other than a bona fide employee or agent any fee or other consideration contingent on the making of this Contract.

32. ENTIRE AGREEMENT

The terms and provisions of the Addenda and Exhibits attached to this Contract are incorporated into and made a part of this Contract. This Contract constitutes the entire agreement between the parties hereto. and all prior understandings or communications, written or oral, with respect to the subject matter of this Contract, are merged and integrated herein. With respect to the Policy described in Addendum 2 and incorporated herein by reference, any item not explicitly discussed in this document which is discussed in said Addendum or Exhibit shall be controlled by the terms of said Addendum or Exhibit.

33. NOTICES

Any notice required to be given by the terms of this Contract shall be deemed to have been given when the same is sent by certified mail, postage prepaid or personally delivered, addressed to the parties as follows:

Employer	Chief of Group Insurance Program Virgin Islands Division of Personnel 34 — 38 Kronprindsens Gade GERS Complex, 3rd Floor St. Thomas, Virgin Islands 00802
Cigna	General Manager , Cigna Healthcare of Florida/Caribbean 1571 Sawgrass Corporate Parkway – Suite 140 Sunrise, FL 33323

34. DEBARMENT CERTIFICATION

By execution of this contract, Cigna certifies that it is eligible to receive contract awards using federally appropriated funds and that it has not been suspended or debarred from entering into contracts with any federal agency. If, during the term of this contract, Cigna shall become ineligible to receive contract awards using federal funds, this contract may be terminated for cause forthwith or at such future date as Employer may specify and Cigna shall not be entitled to payment

Contractor's Initials Y.S.

for any coverage performed under this contract or sub-contract after the effective date of such termination.

35. FALSE CLAIMS

Cigna warrants that it shall not, with respect to this Agreement, make or present any claim upon or against Employer, knowing such claim to be false, fictitious or fraudulent. Cigna acknowledges that making such a false, fictitious, or fraudulent claim is an offense under Virgin Islands law.

36. SEVERABILITY

If any term or condition of this Contract or the application thereof to any person(s) or circumstances is held invalid, such invalidity shall not affect other terms, conditions, or applications which can be given effect without the invalid term, condition, or application.

37. HEADINGS NOT CONTROLLING

Section headings in this Contract are for convenience only and shall have no binding force or effect and shall not enter into the interpretation of the Contract.

38. COUNTERPARTS AND FACSIMILE

This Agreement may be executed in counterparts, each of which shall constitute an original and all of which, when taken together, shall constitute one and the same instrument. The parties agree that documents, including this Agreement, may be transmitted electronically and by facsimile and that executed electronic and facsimile documents, including this Agreement, shall be deemed an original and shall be binding on the party executing said document.

Contractor's Initials Y.S.

IN WITNESS WHEREOF the parties through their authorized representative set their signatures on the day and year indicated.

Witness:

Laura Gosling

Cigna

Yesenia Sanchez
General Manager

Date: 8/23/23

Witness:

Government of the Virgin Islands Health Insurance Board of Trustees

_____

_____
Beverly A. Joseph
Chairperson

Date:_____

Witness:

Virgin Islands Port Authority

_____

_____
Carlton Dowe
Executive Director

Date:_____

Witness:

University of the Virgin Islands

_____

_____
David Hall, Ph.D.,
President

Date:_____

Contractor's Initials Y.S.

IN WITNESS WHEREOF the parties through their authorized representative set their signatures on the day and year indicated.

Witness:

Laura Gosling

Cigna

Yesenia Sanchez
General Manager

Date: 8/23/23

Witness:

Government of the Virgin Islands Health Insurance Board of Trustees

Beverly A. Joseph
Chairperson

Date: 8-25-23

Witness:

_____

Virgin Islands Port Authority

Carlton Dowe
Executive Director

Date: _____

Witness:

_____

University of the Virgin Islands

David Hall, Ph.D.,
President

Date: _____

Contractor's Initials Y.S.

IN WITNESS WHEREOF the parties through their authorized representative set their signatures on the day and year indicated.

Witness:

Laura Gosling

Cigna

Yesenia Sanchez
General Manager

Date: 8/23/23

Witness:

Government of the Virgin Islands Health Insurance Board of Trustees

Beverly A. Joseph
Chairperson

Date:

Witness:

J. Holder

Virgin Islands Port Authority

Carlton Dowe
Executive Director

Date: 9/1/2023

Witness:

University of the Virgin Islands

David Hall, Ph.D.,
President

Date:

Contractor's Initials Y.S.

IN WITNESS WHEREOF the parties through their authorized representative set their signatures on the day and year indicated.

Witness:

Laura Gosling

Cigna

Yesenia Sanchez
General Manager

Date: 8/23/23

Witness:

Government of the Virgin Islands Health Insurance Board of Trustees

Date:

Beverly A. Joseph
Chairperson

Witness:

Virgin Islands Port Authority

Date:

Carlton Dowe
Executive Director

Witness:

University of the Virgin Islands

David Hall, Ph.D.,
President

Date: 9/5/2023

Contractor's Initials Y.S.

Witness:

Virgin Islands Housing Authority

Robert Graham, CPM

Date: 9/5/23

Witness:

Frederiksted Health Care, Inc.

9/31/23

Masserae Spratve-Webster
Chief Executive Officer

Date: 8/31/2021

Approved as to Legal Sufficiency

Department of Justice

By: /s/ Assistant Attorney General

Date: 9/8/23

Approved:

Honorable Albert Bryan, Jr.
Governor of the Virgin Islands

Date: 9/14/23

Approved:

Novelle E. Francis Jr.,
President, 35th Legislature of the Virgin Islands

Date:

Contractor's Initials Y.S.

ADDENDUM 1

TRADITIONAL FUNDING ARRANGEMENT

Article I. Funding Arrangement

During the twelve (12) month term of this contract, the Government Plan shall be operated under a "Traditional Funding Experience Rated and Participating Contract." Under this arrangement, the Government and applicable Employer Entity pays all premiums directly to Cigna. Cigna is then responsible for paying all claims and expenses incurred while the underlying insurance policy (the "Policy") is in effect. This plan is a traditionally funded fully insured participating group health insurance plan. That is, once the required premium is paid in full, the policyholder has no additional liability. Cigna collects the money to pay claims, fund reserves, and cover expenses. Cigna maintains sufficient funds to pay claims that are presented for payment after the policy terminates for covered benefits that were provided prior to termination but that are adjudicated and paid after the policy terminates. These funds are sometimes referred to as claim reserves and such funds are the sole and exclusive property of Cigna earmarked by Cigna to pay claims after the policy terminates. In determining the Premium required to fund the cost of providing benefits under the plan (i.e., claim payments, changes in reserve liability, premium taxes, claim handling and any administrative Expenses and Interest), Cigna takes into account the interest that it expects to earn on claim reserves and reduces the Premium in recognition of that interest income.

The Policy is an experience rated policy. Experience-rating is the process by which rates for a policy period (i.e., a policy year) are prospectively established by use of a retrospective review of the prior policy period's history or experience. Put another way, Cigna's underwriters will review the experience over the past policy period / policy year. Using that experience as a benchmark, the underwriter will establish rates for the upcoming policy period. Because the Policy is experience rated, all Cigna experience-rated coverage under the Policy will be deemed to be one experience-rated program.

The policy is also a participating policy. The policy provides that "As of any Anniversary Date after the policy has been in force for 12 months, the Insurance Company may grant a credit in such amount as it may determine in accordance with Cigna's standard actuarial underwriting policies and procedures, based on experience. The experience under this policy may be combined with the experience under other contracts issued by the Insurance Company or its affiliates and covering the policyholder or its employees."

Contractor's Initials Y.S.

A credit will be granted if the experience produces a Margin. Any credit granted will be offset with prior Deficit(s), if any. The pooled and access fee portion of premium will not be used to determine the year-end Margin or Deficit. Deficits for any one line of experience rated participating coverage may be offset by Margins in that line or in any other line of experience-rated participating coverage, if any.

Article II. Definitions

"**Benefit Program**" is the program of medical benefits found at Addendum 2 of the Agreement.

"**Covered Services**" are those services or supplies specified in the Benefit Program for which benefits will be provided.

"**Deficits**," means the excess of non-pooled claim payments, changes in reserve liability, Expenses and Interest over non-pooled premium. Deficits incurred will carry forward from one policy year to another until such Deficit is paid, in full or is offset by a later years' Margin.

"**Employer Entity**" means the Government or, as applicable, the Authority, UVI, the Housing Authority, FHC or Non-Profit Organizations defined by the Government as eligible to participate under this Agreement.

"**Expenses**" means all non-medical claim costs (exclusive of Interest), including but not limited to claim handling costs, general administrative costs, travel costs necessary to administer the program, on-site representatives, nurse coaches and related costs, risk charges, network access fees, legal and regulatory expenses, including any and all premium taxes and other expenses incurred by Cigna to administer the program.

"**Grace Period**" means the period of 31 days after the Premium Due Date granted for the payment of each premium, during which time the Policy will stay in effect.

"**Margins**" means any excess of non-pooled premium over non-pooled claim payments, changes in reserve liability, Expenses and Interest.

"**Premium Due Date**" means the first day of the month for which premium is due.

"**Run-Off**' means any claim incurred under the insured policy issued by Cigna, which claim was incurred, but not processed, prior to termination of this Agreement. All such Run-Offs shall be the obligation of Cigna.

Contractor's Initials Y.S.

"**Run-Off Period**" means the 12 (twelve) month period following termination of the Agreement during which Run-Off claims must be filed with Cigna in order to be processed.

"**Hospital Confinement upon Termination of this Agreement**". With respect to any Subscriber hospitalized on the date on which this Agreement terminates, Cigna will be responsible for any claims (eligible for payment under the Policy) incurred by such Subscriber through the date of this Agreement's termination. Cigna shall also be responsible for payment of any claims (eligible for payment under the Policy) incurred by the Subscriber through the earliest of the following dates: (1) the date on which the hospitalization confinement (for the condition resulting in confinement as of the date of termination of this Agreement) ends; or (2) the date on which the Subscriber is eligible for other insurance coverage; or (3) the date set forth in applicable "Discontinuance and Replacement" laws.

"**Interest**" means credits/debits based on Cash Flow and Funds. These credit/debits are calculated as part of the annual accounting process. Cash Flow Interest Rates are established on a calendar year basis, and because the experience rated contract is on a fiscal year basis ending 9/30 each year, interest credits/debits will be based on melding the interest rates appropriate to the calendar years within the policy year.

"**Late Payment Interest**" means interest debited against the policy settlement, and included in the renewal buildup as a separate line item due to its materiality, calculated for the contract year and the basis of which is the weighted average delay in premium payments times the relevant late payment interest rate. Since the policy period overlaps calendar years, multiple interest rates will be applied. The formula is as follows: (Weighted Average Delay - 30) / 365 x Policy Premium x Late Payment Interest Rate

"**Subscriber**" means an eligible employee or an employee's dependent, a pre-65 retiree or dependent of a pre-65 retiree, or an under 65 dependent of a retiree 65 and over whose coverage under the Government Plan has become effective.

"**Subscriber's Share**" means the amount of deductible, coinsurance, copayment, and other liabilities required to be paid by the Subscriber under the Benefit Program. Subscriber's Share does not mean an amount payable by the Subscriber as a result of balance billing by a provider of services or supplies. If after Subscriber's Share is paid, an adjustment is made to the amount payable, paid, or charged for a particular service or supply, Subscriber's Share will not reflect the adjustment.

Contractor's Initials Y.S.

Article III. Obligations of Cigna

A. Cigna will review, evaluate, adjudicate, process, and determine whether benefits are due, and pay or not pay claims for benefits under the Benefit Program that are related to services and supplies provided during the term of the Agreement.

B. Cigna will furnish identification cards to all Subscribers. Replacement cards shall be made available to Subscribers upon request. Also available on www.mycigna.com

C. Cigna will provide the Employer the claims reports of the types and with the frequencies set forth in the Agreement. Cigna may adjust all such information provided to the Employer to prevent the disclosure of the identity of any Subscriber or other patient who is the subject of the information.

D. As provided in the Agreement, Cigna will prepare a booklet summarizing the benefits available to Subscribers under the Benefit Program, including a Summary of Benefits and Coverage that meets the requirements of PPACA.

E. The obligations of Cigna set forth in this Addendum which are performable outside of Cigna's geographic service area may be subcontracted to another provider that is located in or authorized to perform the obligations in the relevant geographic service area.

F. Cigna may seek recovery of payments made to ineligible persons or to providers for services rendered to ineligible persons.

G. Cigna will maintain current individual benefit records on all Subscribers.

Article III.A. Obligations of the Employer

A. The Employer or applicable Employer Entity shall pay premiums to Cigna in accordance with this agreement. The amount to be paid is set out in Exhibit A to this addendum. The Employer Entity will send to Cigna a copy of the ACH premium transfer document when payment is made.

B. The documents comprising the Benefit Program are identified in Addendum 2 and incorporated by reference. The Employer will notify Cigna in writing of any changes the Employer desires to be made to the Benefit Program at least 60 days prior to the proposed effective date of the changes. Such changes must be agreed to by Cigna before they become effective. There may be an additional charge for such changes and such changes are subject to Cigna's underwriting practices and guidelines.

Contractor's Initials Y.S.

C. The Employer or applicable Employer Entity will provide to Cigna a complete and current listing of all Subscribers under the Benefit Program, in a form and medium agreed to by the parties. The Employer or applicable Employer Entity will also provide notice, in a form and medium agreed to by the parties, in advance of any additions to or subtractions from the listing by forwarding electronic eligibility data to Cigna for the affected individual that includes the nature of the change and the effective date of the change. Cigna will rely on the listing and changes to the listing. The Employer or applicable Employer Entity agrees that this listing may be subject to audit and verification by Cigna. Audits may be performed during business hours after at least seven (7) days' notice.

In addition, the parties will establish a documented electronic eligibility process, with "default logic" as a safeguard against occasional errors in communicating changes in eligibility in the manner described in the preceding paragraphs. This default cancel process shall not be effective until reduced to a written protocol signed by Employer and Cigna. The default cancel process may be terminated by Cigna if Cigna determines that too many exceptions are occurring. Employer acknowledges that default cancel creates an assumed termination that will generally be a date later than the termination date reflected in Employer's eligibility system. In the event of terminations due to default cancel logic, the assumed termination date shall be used to process claims and for the payment of premium including the determination of any premium credits. Cigna shall provide the Employer with the following reports separated by entity and

participant class:

a. Report of enrollment totals (monthly)

b. Report of mismatched records (monthly)

Any requests to Cigna to reinstate eligibility for a person terminated by the Employer in error shall be in writing, shall identify the cause of the error (to allow root cause analysis by the Employer and Cigna), and shall be signed by the Chief of Group Health Insurance of the Government of the Virgin Islands or its designee.

D. The Employer will distribute forms for enrollment in the Benefit Program, which have been agreed to by the parties, to those members who are eligible for coverage under the Benefit Program. The Employer will forward to Cigna, in a medium agreed to in advance by the parties, completed forms. Clerical errors or delays in recording or reporting dates will not:

Contractor's Initials Y. S.

- invalidate coverage which would otherwise be in force; and
- continue coverage which would otherwise terminate.

Upon discovery of errors or delays, an equitable adjustment of charges and benefits will be made consistent with Cigna's then current enrollment and underwriting policies. The Employer and Cigna acknowledge that the written consent of Subscribers may be required by statute before the release of confidential medical information necessary to substantiate the payment of fees for health care services or supplies provided to Subscribers or otherwise necessary to Cigna's performance of obligations under this Agreement. The Employer agrees to obtain and maintain these consents on file. The Employer will produce these consents upon request by Cigna, or its designees, and permit Cigna or its designees to audit these consents upon 48 hours' notice. The Employer and Cigna recognize that failure to produce such consents could result in harm to Cigna. Accordingly, it is hereby agreed and understood that, absent provision by Employer to Cigna of the consents referenced herein, Cigna shall have no obligation to provide the Employer with any patient-identifiable information. Employer agrees, to the extent permitted by law, to indemnify Cigna and hold it harmless for any damages, expenses, or liabilities, which may accrue due to a failure on the part of Employer to fulfill its obligations under this provision.

Article IV. Payment Terms

A. Payment by each Employer Entity.

1. Cigna shall, on a monthly basis during the term of the Contract, bill each Employer Entity for payment of premiums. Each Employer Entity shall pay such premium by the end of the month following the end of the Grace Period. Before then, the Policy may not be terminated for nonpayment.

2. If the Employer or any applicable Employer Entity fails to pay any premium by the end of the month following the end of the Grace Period for payment of the premium, Cigna may terminate the Contract and the coverage under the Policy with respect to such Employer or applicable Employer Entity for non-payment as of the end of the Grace Period.

3. All outstanding premiums shall be paid "as billed" by Cigna both as to past invoices and to all future invoices. As to the past (except as provided herein) or the future,

Contractor's Initials YS.

premium credits for persons who are not eligible will be limited to a retrospective period of not more than 60 days before the date that Cigna is notified of the loss of eligibility plus three business days. Such credits will be reflected on monthly statements prepared by Cigna.

Article V. Confidential Information

A. During and after the term of this Agreement, Employer will not release and will protect all Confidential Information that it receives or becomes aware of pursuant to or in the course of the performance of the obligations of this Agreement except pursuant to:

(1) Virgin Islands or federal law;

(2) court order;

(3) this Agreement;

(4) another agreement between the parties specifically regarding the subject matter of this Paragraph; and

(5) as necessary to establish and maintain the Benefit Program.

B. As used in this Article. "Confidential Information" includes, but is not limited to, the business practices, strategies, know-how, procedures, methods, methodologies, provider relationships and systems used by Cigna in administering the Benefit Program. "Confidential Information" shall also include all information, in whatever form or medium, that is deemed "confidential" under Virgin Islands or federal law or rules and regulations.

C. During and after the term of this Agreement, Employer will not release and will protect all Confidential Information unless released pursuant to an agreement between the parties or as necessary to establish and maintain the Benefit Program.

D. The obligations of this Article shall survive the termination or expiration of this Article or the Agreement.

E. If Employer releases Confidential Information contrary to the terms of this Article, the Employer will take all steps necessary to assure that the person to whom the Confidential Information is released does not release and does protect the Confidential Information.

Contractor's Initials Y.S.

F. A breach of the terms of this Article will cause immediate and irreparable harm to Cigna. As such, in addition to any other rights or remedies available at law or in equity, Cigna is entitled

to injunctive relief to restrain or enjoin such breach.

Article VI. Health Information

A. During and after the term of this Agreement, the Employer will not release and will protect all Health Information that it receives or becomes aware of pursuant to or in the course of the performance of the obligations of this Agreement except pursuant to:

(1) Virgin Islands or federal law;

(2) court order;

(3) this Agreement;

(4) another agreement between the parties specifically regarding the subject mailer of this Paragraph; and

(5) and as necessary to establish and maintain the Benefit Program.

B. "Health Information" means any information that is created or received by a health care provider, the Employer, or Cigna and relates to:

(1) the past, present, or future physical or mental condition of an individual;

(2) the provision of health care to an individual; or

(3) the past, present, or future payment for the provision of health care to an individual.

This definition shall include any additional information which may be defined as Health Information by any Virgin Islands or U.S. laws or regulations.

C. During and after the term of this Agreement, Employer will not release and will protect all Health Information unless released pursuant to applicable Virgin Islands and U.S. laws or regulations. Releases of such information may require the consent of the individual who is the subject of the information and improper releases may be subject to penalty.

D. To the extent permitted by applicable law, Employer will indemnify, hold harmless and release Cigna, its employees, and agents against any and all liabilities, losses,

Contractor's Initials Y.S.

obligations, risks expenses (including attorneys' fees), costs, damages, and judgments and against any and all claims and actions actually or allegedly based upon, arising out of, or in any way connected with:

- Cigna's disclosure of Health Information to the Employer or any agent of the Employer; or
- disclosure or use of Health Information by the Employer or agent, regardless of the source of the Health Information.

E. If any applicable law or regulation is enacted, or a decision of a regulatory agency or judicial body is issued which prohibits Cigna from disclosing Health Information, Cigna shall be relieved of its obligations under this Agreement, to the extent required by the law or decision.

F. The obligations of this Article shall survive the termination or expiration of this Article or the Agreement.

Article VII. Liability and Notice of Cause of Action

Employer will promptly notify Cigna of any cause or action brought against the Employer or any agent of the Employer (of which cause or action the Employer has knowledge) for which Cigna may seek indemnification. Employer may not compromise or settle any such cause or action arising under this Contract without the Cigna's concurrence, and the Employer warrants and represents that its agents will do the same. Cigna may in its discretion choose to undertake or take control of the defense of any such cause or action in which it is a named party.

Contractor's Initials YS

EXHIBIT "A"
to Addendum No. 1

PREMIUM RATES:

For the first year of this Contract, Cigna will offer a premium credit of $Seven million and 00/100 dollars.

OAP/Comprehensive Coverage Missouri & Oklahoma & Texas FULL	TOTAL PREMIUM
Active Employees	
Employee Only	$962.98
Employee & Family	$1,683.84
Retirees Under 65	
Retiree Only Under 65	$1,248.52
Retiree + Dependents Under 65	$2,231.48
Retiree + Dependents Over 65	$1,720.74
Pre-65 Dependents of Post 65-Retirees	
Pre-65 Dependents of Post 65-Retirees	$1,248.52
Disabled Enrollees – US/VI/PR	
Disabled Medicare Primary <65	$575.16
Disabled Dependent <65	$1,271.68
Disabled Dependent >65	$951.78

Contractor's Initials Y.S.

OAP/Comprehensive Coverage Missouri & Oklahoma & Texas - LIMITED	TOTAL PREMIUM
Active Employees	
Employee Only	$957.20
Employee & Family	$1,673.74
Retirees Under 65	
Retiree Only Under 65	$1,241.04
Retiree + Dependents Under 65	$2,218.10
Retiree + Dependents Over 65	$1,710.42
Pre-65 Dependents of Post 65-Retirees	
Pre-65 Dependents of Post 65-Retirees	$1,241.03
Disabled Enrollees	
Disabled Medicare Primary <65	$571.72
Disabled Dependent <65	$1,264.06
Disabled Dependent >65	$946.08

OAP Medical Active & Early Retirees USVI and US	TOTAL PREMIUM
Active Employees	
Employee Only	$962.98
Employee & Family	$1,683.84

Contractor's Initials Y.S.

Retirees Under 65	
Retiree Only Under 65	$1,248.52
Retiree + Dependents Under 65	$2,231.48
Retiree + Dependents Over 65	$951.78
Pre-65 Dependents of Post 65-Retirees	
Pre-65 Dependents of Post 65-Retirees	$1,248.52
Disabled Enrollees	
Disabled Medicare Primary <65	$575.16
Disabled Dependent <65	$1,271.68
Disabled Dependent >65	$951.78

Indemnity Medical Puerto Rico	**TOTAL PREMIUM**
Active Employees	
Employee Only	$962.98
Employee & Family	$1,683.84
Retirees Under 65	
Retiree Only Under 65	$1,248.52
Retiree + Dependents Under 65	$2,231.48
Retiree + Dependents Over 65	$1,720.74
Pre-65 Dependents of Post 65-Retirees	

Contractor's Initials Y.S.

Pre-65 Dependents of Post 65-Retirees	$1,248.52

Disabled Enrollees

Disabled Medicare Primary <65	$575.16
Disabled Dependent <65	$1,271.68
Disabled Dependent >65	$951.78

The rates set forth above include all administrative charges for the services agreed to be made available to the Employer.

Contractor's Initials Y.S.

ADDENDUM 2

BENEFIT PROGRAM

This Addendum is to address the benefit provisions for the Agreement between the Employer and Cigna. The Agreement between the Employer and Cigna contemplates the issuance of a group benefit policy, including a certificate of insurance that describes the benefits under the policy, that sets forth the terms of the benefits under this Agreement. Cigna will provide a final group benefit policy (the "Policy") as of the effective date as of this Agreement, and such Policy shall be incorporated herein by reference as if set forth in full in this Addendum.

The benefits as more fully summarized and specified are contained in the Certificate of Insurance and is provided to each participant in Employer's health benefit plan.

Contractor's Initials Y.S.

ADDENDUM NO.3
2023-2024 Performance Guarantees
The Government of the US Virgin Islands

CLAIM METRICS

Time to Process

92% of claims processed in 14 calendar days, reported monthly at the account level.

PENALTY $80,952.38

99% of claims processed in 30 calendar days, reported monthly at the account level. Results are reported quarterly.

PENALTY $80,952.38

Financial Accuracy

Medical Financial Accuracy. Measured for the Term of the Agreement, results will meet or exceed: 99% of total audited claims dollars correctly paid. Results will be measured at the Account Level.

PENALTY $80,952.38

Claim Payment Accuracy

Medical Payment Accuracy. Measured for the Term of the Agreement, results will meet or exceed: 97% of total audited claims are correctly paid. Results measured at the Account Level.

PENALTY $80,952.38

INQUIRY METRICS

Average Speed of Answer (ASA)

The average speed of answer (ASA) for a phone call to the Call Center(s) during the Guarantee Period shall be no longer than 45 seconds. The calculation of ASA is based on all calls received by the Call Center(s) that are serviced in the Special Account Queue. Results are provided monthly.

PENALTY $80,952.38

Contractor's Initials Y.S.

Call Abandonment Rate

Medical Call Abandonment Rate — measured for the Term of the Agreement, results will not exceed: 3% of calls received by Call Center(s) terminated. Results measured at Special Account Queue.

PENALTY $80,952.38

First Call Resolution

Medical First Call Resolution. 90% of calls resolved on first call, 45 day look back/forward. Results measured at the account level.

PENALTY $80,952.38

Account Management

Cigna's Account management Sales Team commits to providing services of such quality as will result in Cigna achieving a composite score of 3.0 or better on the Account Management Report Card. The Account management Report Card will be distributed on a quarterly basis. The composite score will be calculated at the end of the term upon receipt of the fourth quarterly survey.

PENALTY $80,952.38

Contractor's Initials YS.

Exhibit A – Account Management Report Card

Rating Methodology:

5 = Completely Satisfied

4 = Very Satisfied

3 = Satisfied

2 = Somewhat Satisfied

1 = Dissatisfied

Client/Company Name:

Completed By (please print): _____

Client Signature_____

Date completed: _____

Telephone #:_____

At the end of each quarterly period, please complete the box with the score that most closely reflects your level of satisfaction with the local account management team with respect to the following service categories. A separate quarterly report card must be completed, signed and dated each quarter.

Measurable Need	**1st Q**	**2nd Q**	**3rd Q**	**4th Q**	**Composite to be completed by PG Unit**
1. Provides effective support in preparing for, and conducting open enrollment events/sessions.					
2. Provides client with timely notification of issues impacting members.					
3. Responds to client's issues & questions in a timely, comprehensive manner.					
4. Develops, follows through on action plans; effective coordination to resolve open issues.					

Contractor's Initials Y.S.

Measurable Need	1st Q	2nd Q	3rd Q	4th Q	Composite to be completed by PG Unit
5. Is accessible and attends scheduled meetings.					
6. Delivers agreed upon reports and communication of Cigna results on time.					
Account Management Composite Score (All Categories)	N/A	N/A	N/A	N/A	

Fill in for each quarterly period:

Date Sent to client: __/ /__ __/ /__ __/ /__ __/ /__

Date Returned by client: __/ /__ __/ /__ __/ /__ __/ /__

If you rated any of the above categories less than "Satisfied" (3), please tell us why:

X 1st Q:

X 2nd Q:

X 3rd Q:

End of Year Comments:

Please return this form to: _____

Contractor's Initials Y.S.

ADDENDUM 4

Forces Majeure or Majesture

The parties agree that Forces Majeure or Majesture such as acts of God or nature, fires, floods, storms, or earthquakes may prevent one or both parties from performing its obligations under the Agreement. Therefore, the parties agree that the following provisions shall apply.

Article I Notice

In the event Forces Majeure or Majesture may prevent performance of one party's obligations, that party shall notify the other party in writing as soon as reasonably possible.

Article II In the Event Cigna Cannot Perform

In the event Cigna, or its subcontractors, cannot perform its obligations due to Forces Majeure or Majesture. Cigna shall make all reasonable efforts to resume performance of such obligations. Such efforts shall include, but not be limited to, the following:

a. Location of a facility by which claims payment operations would continue within 2 business days of a force majeure event

b. Resumption of customer service operations within 2 business days of such event. Operations established pursuant to this section should be in place to handle not only ongoing claims issues, but historic claims and customer service issues that may arise due to ongoing service. The following services shall be included in such operations:

Pre-authorizations

Medical Case Management

Coordinated transfer of cases to the US Mainland

PPO Network management

Payment of claims

In addition, Cigna is responsible to retain historic record of claims data in a manner that would protect its integrity in the event of such a force majeure event. Cigna shall have safeguards to protect incoming data —paper or otherwise — in a manner by which no more than one day's claims receipts would be lost.

Contractor's Initials Y.S.

Article III In the Event the Employer Cannot Perform

a. ***Non-financial obligations***

In the event the Employer cannot reasonably perform its "non-financial" obligations due to Forces Majeure or Majesture, the Employer shall make all reasonable efforts to resume performance of such obligations. For the purposes of this Addendum, "non-financial" means obligations other than payment of premium.

b. ***Financial Obligations***

In the event the Employer cannot reasonably perform its financial obligations within the time periods allotted in the Agreement (e.g. the "Grace Period") due to Forces Majeure or Majesture events, the Employer shall immediately notify Cigna and shall immediately request a "90 Day Premium Delay." Such notice shall be mailed within 30 days of the occurrence of the Forces Majeure or Majesture.

Article IV 90 Day Premium Delay

Upon receiving a valid request to invoke the 90 Day Premium Delay, Cigna shall suspend any efforts to collect premium from the Employer. The 90 Day Premium Delay shall be considered effective on the day after the last date for which premium was paid.

Example 1: The Employer's premium is fully paid through August 31. On September 15, the Employer makes a valid request for a 90 Day Premium Delay. The Premium Delay is deemed to be effective on September 1, the day after the last day for which premium was paid. The Premium Delay shall extend for 90 days to December 1.

The 90 Day Premium Delay does not relieve the Employer from the obligation to pay for the coverage in effect during the 90 Day Premium Delay.

a. Cigna Obligations

Cigna shall not invoice the Employer for 90 days from the last due date prior to the 90 Day Premium Delay taking effect. Cigna shall continue to perform its obligations under the Agreement as required. When Cigna resumes invoicing the Employer, such invoices shall be done in accordance with the terms of the Agreement, except that such invoices shall be for 100% of the premium owed:

(i) to the period during which the 90 Day Premium Delay was in effect, and during which premiums were not received;

Contractor's Initials YS.

(ii) then to any period after the 90 Day Premium Delay for which premiums were not collected;

(iii) finally to any current or future period for which premiums are due.

Example 2: The Employer requests a premium delay that takes effect on September1. Cigna does not invoice the Employer for premiums during September, October, or November. Cigna invoices the Employer for premiums in December, which the Employer pays. The premium received is applied by Cigna to the amount due for the month of September. Premiums received in January will be applied to October, and so on.

Application of new premium payments toward delayed premium payments shall not extend beyond the annual term of the Agreement. Except, however, moneys paid by the Employer in excess of the premiums due in the new contract year will be applied by Cigna to reduce outstanding amounts, including periods for which moneys are owed due to the invocation of a 90 Day Premium Delay.

Example 3: The Employer has invoked a 90-day premium delay and made subsequent payments described in Example 1. On March 31, the Contract Year ends. The Employer pays the monthly premium for April. This amount is NOT applied to the outstanding balance from the previous year. In May, the Employer pays an amount equal to one and a half times the monthly premium invoiced. The amount in excess of the May premium shall be applied by Cigna to the amount outstanding due to the 90-day premium delay.

Any premiums not collected during the annual term of the Agreement shall remain due to Cigna.

b. Agreement Provisions Applicable

Delayed premiums shall be subject to all provisions of the Agreement regarding invoicing, payment, and late charges, if any. Delayed premiums shall be considered late payments and subject to any interest and fees provided for in the Agreement or the addenda.

c. Advanced Payment

Nothing in this provision shall be construed to limit or prevent the Employer from reimbursing Cigna all or some of the moneys owed due to the 90 Day Premium Delay earlier than might be required. Such advanced payments shall diminish any interest charges, late fees, or other penalties, as is appropriate under the terms of the Agreement and the addenda and exhibits thereto.

Contractor's Initials Y.S.

d. Not to Be Construed as Compromise or Settlement

The application of funds under this Article is in no way to be construed as constituting a compromise and settlement of the full amounts owed under the Agreement.

e. 90 Day Premium Delay Inapplicable

In the event that the Employer properly requests, and Cigna invokes, the 90 Day Premium Delay in accordance with this section, such 90 Day Premium Delay will be revoked if the Employer is determined to be paying other debts and obligations (not due and owing to Cigna) on a timely basis. Upon revocation of such 90 Day Premium Delay pursuant to this subsection (e), all premiums due and owing will be due immediately due and payable, and failure to make such payments will result in termination of the underlying Agreements and policy, subject to the notice requirements set forth therein.

Article V. Continuing Responsibilities

Any delay in performance granted to either party due to Forces Majeure or Majesture do not release either party from the responsibility for fulfilling the delayed obligations required by the Agreement and its addenda, except as may be permitted by the Agreement or its addenda. Failure to perform these obligations may result in either party invoking the termination provisions of the Agreement as may be appropriate.

Contractor's Initials YS

ADDENDUM 5

LOCAL SERVICE CENTERS IN THE VIRGIN ISLANDS

Article I Days and Hours of Operation

Cigna agrees that it will operate two (2) Service Centers, one on St. Croix and the second on St. Thomas, in the Virgin Islands. Each Claims Office and Service Center shall be staffed by a customer service representative. The hours of operation of the Claims Offices and Service Centers shall be as follows:

- 5 days a week in St. Thomas, from 8:00am to 5:00pm, and
- 5 days a week in St. Croix, from 8:00am to 5:00pm.

Article II Services Provided

Cigna will provide both walk-in and telephonic customer service and claims processing services from the Claims Offices and Service Centers. The types of services to be offered include, but are not limited to:

a. Customer Services

- provide telephone customer assistance
- enrollment assistance
- location of participating providers
- pre-certification assistance
- claim resolution assistance
- accept and input "paperless" claims
- walk-in service
- replacement of ID cards for a nominal fee.

When the Service Centers are not open, telephone calls will be referred to a centralized unit, thereby providing 24-hour toll-free access to service.

Contractor's Initials Y.S.

ADDENDUM NO. 6

Electronic Claims Processing System

In recognition of provider concerns over prompt payment of claims and for ease of Administration, and as required by law, Cigna utilizes electronic claim clearing houses.

Contractor's Initials Y.S.

ADDENDUM NO. 7

PROVIDER CONTRACTING

Cigna agrees that it will offer contracts to any provider licensed to practice in the Virgin Islands and willing to accept the rates and terms offered by Cigna, provided, however, that such provider must comply with and satisfy Cigna's National Credentialing and Recredentialing Policy then in effect.

Contractor's Initials Y.S.

ADDENDUM NO. 8
Impact of Legislation

Whereas, it is possible legislation may be enacted that directly affects the administration of this Agreement in ways that also may affect the cost of this program; and Whereas, the parties agree that Cigna should not be subjected to unexpected changes in the program that will result in higher costs without an opportunity to adjust the premium rates quoted;

Therefore the parties agree as follows:

1. Cigna is permitted to review its premium rates should legislation be enacted, or regulations adopted, after the signing of the Agreement and prior to the anniversary date of the Agreement which requires changes in the way the Government Program is administered, or in the benefit structure of the program, and for which the premium rates quoted by Cigna do not provide. Such legislation includes but is not limited to legislation that:

   a. changes in the way claims are processed;

   b. affects the way Cigna may contract with providers, including

      Cigna's right to do business with any particular provider or group of providers

   c. requires changes in the amount providers may be reimbursed;

   d. mandates benefits or services that must be covered or the level of coverage to he provided;

   e. introduces any other requirement that materially affects the cost of the program.

2. Cigna shall notify Employer of the results of its review within 90 days after the adoption of such legislation or regulations.

3. Cigna may adjust the premium rates quoted to the Employer to reflect changes in costs due to any statutory or regulatory requirements.

4. Such changes in rates shall be effective for the next billing period after the date on which Cigna submits the rate changes to the Employer except however:

   a. the rate changes shall not be effective before the effective date of the statute or regulation,

Contractor's Initials Y.S.

b. such changes in rates shall not be effective prior to their being presented to Employer by Cigna unless the effective date of the statute or regulation predates the rate changes being presented and Cigna is completed to comply with the statute or regulation at this earlier date.

5. Cigna has the right to review its rates during the first 90 days after the effective date of the Agreement to determine if legislation passed after Cigna signed the Agreement has an affect on the Agreement sufficient to cause an impact on the premium rates attached to the Agreement.

Contractor's Initials Y.S.

ADDENDUM NO. 9
Health Improvement Centers

Cigna in partnership with the Government of the Virgin Islands GESC/Health Insurance Board of Trustees ("GESC Board") shall maintain two on-site Health Improvement Centers (one each in St. Thomas and St. Croix) ("Centers" or "Center") for the benefit of US Virgin Islands Government employees ("Participants"), facilitating individual health risk assessments, biometric screenings, and health coaching based on the risk factors identified. In addition, seminars can be conducted at Government Agencies to discuss medical issues for the benefit of US Virgin Islands Government employees. These local centers shall be staffed with two registered nurses ("RN's") four total full-time employee's (FTE's) for the Territory and managed through Evernorth Direct Health, LLC ("Evernorth").

Cigna shall arrange the services below for the benefit of US Virgin Islands Government employees, through its affiliate, Evernorth. The Scope of Services is as follows:

A. Staffing for Health Improvement Centers; Days and Hours of Operation

Each Center is staffed by two RN's. The Centers are located on both St. Thomas and St. Croix. They are open Monday through Friday from 8:00 am to 5:00 pm, following the holiday schedule of the Government in the Territory, with flexibility in hours as agreed to by the parties to meet the needs of the USVI.

B. Health and Wellness Services

1. *Support an Annual Biometric Event*
    a. *Assist with event logistics: suggest times of biometric event, measurements of location space for holding event, conduct a pre-event interest survey to gauge estimated participation*
    b. *Assist with biometric consults on the day of biometric event*
    c. *Promote event (signage)*
2. *Support health risk assessment ("HRA") Completion*
    a. *Assist with paper HRA completion delivered to employees*
    b. *Provide health coaching/consultation on HRA results*
    c. *Refer to clinical programs where appropriate based on HRA results*

Contractor's Initials YS.

3. *Deliver Onsite Group Seminars*

   a. *Seminars as requested.*

   b. *Can be a presentation via a "lunch and learn" format or as a seminar*

4. *General Health Promotion*

   a. *Staff a monthly "Stop By" booth theme that is specific to each month, also at annual Wellness Fair*

   b. *Monitor and manage bulletin board topic of the month*

   c. *Engage employees to establish coaching referral*

C. Onsite Health Coach Services

Onsite Wellness Coaching Activities

1. *Nutrition*

   a. *Establish nutritional health goals collaboratively with Participants*

   b. *Establish coaching duration and frequency collaboratively with Participants, based on Health Coach prescribed plan*

   c. *Deliver topic specific education and referral as needed*

2. *Physical Activity*

   a. *Establish physical activity health goals collaboratively with Participants*

   b. *Establish coaching duration and frequency collaboratively with Participants, based on Health Coach prescribed plan*

   c. *Deliver topic specific education and referral as needed*

3. *Wellness Education and Referral*

   a. Prevention

   b. Women's Issues (includes menopause, infertility)

   c. Children's Health Issues (includes education on vaccines, healthy eating, exercise, etc.)

Contractor's Initials YS

d. Men's Health

e. Sleep

f. Stress

g. Weight

h. Other

i. Establish coaching duration and frequency collaboratively with Participant,) based on Health Coach prescribed plan

4. High Blood Pressure

a. Establish high blood pressure reduction goals collaboratively wit Participants and their treating physicians

b. Establish coaching duration and frequency collaboratively based on Health Coach prescribed plan

c. Deliver condition specific education and referral as needed

d. Identify any gaps in care, educate & assist in the closure

5. High Cholesterol

a. Establish cholesterol reduction goals collaboratively

b. Establish coaching duration and frequency collaboratively with Participants and their treating physicians

c. Deliver condition specific education and referral as needed

d. Identify any gaps in care, educate & assist in the closure

6. Maternity

a. Educate on and refer to Health Pregnancy/Healthy Baby program or Healthy Babies

b. Educate on importance of prenatal care

c. Leverage clinical guidelines used in existing programs (Health Advisor, iPHT)

d. Coordinate lactation consultant

Contractor's Initials YS.

7. *Benefits Navigation*

a. *Deliver basic information regarding benefit resources and tools to maximize benefits – specific guidance around cost and quality tools, myCigna.com resource, etc.*

b. *Refer to USVI Government Human Resources/Benefits Administration for detailed plan questions, concerns, or issues requiring escalation*

c. *Educate and refer to plan clinical programs (internal & external)*

D. Tools and Testing Supplies Related to Health Coaching Activities

1. *Coaches are supplied with the tools to support their coaching efforts. Tools include, but may not be limited to:*

a. *Tanita bio-electrical impedance scale*

b. *Blood Pressure assessment equipment (manual or electronic)*

c. *Cholestech Analyzer to perform:*

i. *Total Cholesterol*

ii. *High Density Lipoprotein*

iii. *Blood Glucose*

d. *Testing supplies: cassettes, gauze, lancets, pipettes, alcohol preps, band-aids*

e. *Stadiometer for height assessment*

f. *SECA waist circumference tape for assessment of waist*

g. *Coaching Educational tool kit*

E. Reporting for Health Coach Services

1. *Participant Reports:*

a. *Post coaching encounter Participants receive a coaching "score card" which is a summary of the visit and assigned goals. This is a visual educational tool and reminder.*

2. *Client Reports*

Contractor's Initials YS.

a. *Annual Screening report:*

i. *This annual report provides the aggregated testing values by risk of the screenings conducted and highlights emerging trends and intervention opportunities within the tested population. Data is provided in compliance with applicable privacy law and regulation.*

b. *Monthly HeART (Health Advocacy Reporting Tool) Reports*

i. *This monthly report provides an overview of the utilization of coaching services and health promotion activities within the USVI.*

F. Health Education Only

The services described in Addendum 9 **do not** constitute professional medical advice or the diagnosis or treatment of Participants who utilize the Health Coach services, and are intended to be educational in nature only.

G. Maintenance of Health Improvement Centers

Employer shall be responsible for ongoing maintenance and upkeep of the buildings housing the Health Improvement Centers.

H. PTO and Leave

1. Employer acknowledges and agrees that the Health Coaches shall be entitled to paid time off (PTO) and other leave ("Leave") in accordance with Cigna's standard policies and procedures ("Policies"). PTO shall include: (a) vacation days; (b) personal days; (c) holidays; (d) floating holidays; (e) sick leave, with the exception that holidays shall conform to the holiday schedule of the Government in the Territory; and (f) other PTO in accordance with applicable law and current Cigna Policies. Leave shall include: (a) military leave; (b) Family Medical Leave (FMLA); (c) disability leave; and (d) other leave in accordance with applicable law and current Cigna Policies.

2. Cigna shall not be required to make any adjustments to any fees paid for PTO and Leave granted to the Health Coaches in accordance herewith.

3. During the term of this Addendum, and for a period of one (1) year after expiration or termination of this Addendum for any reason, Employer shall not directly or indirectly, alone or in concert with others, solicit or entice the employee or independent contractor engaged by Cigna or Evernorth to provide services under this Agreement, to leave the employment or engagement of Cigna or Evernorth in order to provide substantially similar

Contractor's Initials Y.S.

services as those provided in this Agreement, to or on behalf of the Employer or to otherwise work in competition with Cigna, Evernorth or their affiliates.

I. Additional Provisions

Additional provisions as mutually agreed to by the parties.

J. Potential Future Provisions

The parties contemplate potential future implementation of onsite health centers, staffed by certain mid-level clinical practitioners and/or physicians, as may be mutually agreed upon by the parties, and subject to a definitive written agreement between the parties.

K. Van Services.

Evernorth shall secure and maintain two Mercedes-Benz Springer Cargo Vans (Sprinter HR 144"WB), to be transported to the USVI (one to St. Thomas, and one to St. Croix). The vans will be garaged at the following locations:

- 8000 Nisky Shopping Center Suite 740
  St. Thomas Virgin Islands 00802

- 4500 Sunny Isles Medical Center Suite 19
  Christiansted, VI 00820

Evernorth will hire two full-time employees to serve as drivers for each of the vans. The vans will be available for the RN coaches to be able to provide services on a "mobile" basis. The schedule will be flexible based on need and the coaches will coordinate their calendars with office site needs to allow for "in-office" and "on-road" days as needed. The coaches will provide their existing scope of services (including coaching and biometric screenings) except for vaccinations to the currently-eligible population.

Contractor's Initials YS

ADDENDUM NO. 10
HEALTH IMPROVEMENT FUND

Cigna recognizes Employer's commitment to better health. Therefore, the health improvement fund discussed in said contract is to be used to help Government Employees and their Dependents make better choices about their health and well-being. Cigna will assist Employer in developing a plan to improve health and productivity, focus on behavior change and health status improvement and create a health and wellness engagement program.

The health improvement fund can help Employer achieve its health improvement goals and may be utilized for things such as:

- Rewards for wellness program participation (excluding cash),

- Activity and challenge programs related to wellness,

- Onsite health and wellness classes,

- Health awareness communications,

- Wellness speakers,

- Onsite screenings such as flu and biometrics.

Examples of ineligible expenses include:

-Paid time off,

-Premium reductions,

-Employee holidays or discounts,

-Prescriptions,

-Charitable donations (unless a race or walk entry fee),

-Onsite clinic costs, food (unless related to a healthy cooking demonstration or nutrition initiative),

-Employer staff, or

-Broker, producer or consultant fees.

Contractor's Initials Y.S.

The money in the health improvement fund will be available at the beginning of said contract. Any funds not used by the end of said contract will be forfeited; they do not roll over from year to year. Cigna will manage the fund and must pre-approve an expense to ensure fund dollars remain and ensure it is an eligible expense. Cigna will provide quarterly health improvement fund expenditure reporting.

Contractor's Initials Y.S.

ADDENDUM NO. 11

Motivate Me®

Section 1. Basic Services

Cigna shall administer the Employer's selected standard/custom incentives program that provides participants with Employer's pre-determined rewards in combination with the following program:

> Value Package: Base package plus telephonic coaching for progressing or for achieving health goals, in association with Your Health First and/or Integrated Personal Health Team clinical programs.

Section 2. Employer Responsibilities

Employer must have in effect at all times a Cigna-administered group medical insurance policy and/or group service agreement of one of Cigna's HMO affiliates and one or more clinical programs (i.e., Your Health First, Personal Health Team. Integrated Personal Health Team, Lifestyle Management Program, Healthy Awards or Healthy Pregnancy, Healthy babies) that works in conjunction with the MotivateMe® incentive option.

Section 3. Charges

The performance of services described in Section 2 shall be included at NO ADDITIONAL COST.

Section 4. Privacy Addendum (Business Associate Agreement)

The Privacy Addendum (Business Associate Agreement) that follows is applicable to Cigna's administration of Employer's MotivateMe® incentive option.

Contractor's Initials Y.S.

ADDENDUM NO. 12

Cigna Funded Optional Services

- **Annual COBRA Management - $55,000.**
- **Annual BENTEK Management- $285,000.**
- **MASA Agreement- $300,000.**
  - **Members who use MASA for Medical Air Transport contractual agreement.**

Contractor's Initials Y.S.

Privacy Addendum
("Business Associate Agreement")

I. GENERAL PROVISIONS

Section 1. Effect. Upon the first exchange, transmission, creation, or maintenance of Protected Health Information (PHI) by Cigna ("Effective Date"), the terms and provisions of this Addendum are incorporated in and shall supersede any conflicting or inconsistent terms and provisions of (as applicable) the Services Agreement to which this Addendum is attached, including all exhibits or other attachments to, and all documents incorporated by reference in, any such applicable agreements (individually and collectively any such applicable agreements are referred to as the "**Agreement**"). This Addendum sets out terms and provisions relating to the use and disclosure of Protected Health Information ("**PHI**") without written authorization from the Individual. To the extent there is a conflict between the Agreement and this Addendum, this Addendum shall control. Any ambiguity in this Addendum resolves in favor of compliance with HIPAA rules.

Section 2. Amendment. Cigna, on behalf of itself and its affiliates and subsidiaries that perform services under the Agreement or other agreements (collectively referred to as **"Cigna"**), Employer (also referred to as "**Plan Sponsor**"), and the group health plan that is the subject of the Agreement (also referred to as the **"Plan"**) acknowledge that the foregoing provisions are designed to comply with applicable laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160 to 164) ("**HIPAA Privacy and Security Rules**"). Cigna shall provide written notice to the Plan to the extent that any regulation or amendment to regulations promulgated by the Secretary requires changes to this Addendum. Such written notice shall include any additional amendment required by any such final regulation and this Addendum shall be automatically amended to incorporate the changes set forth in such amendment provided by Cigna to the Plan, unless the Plan objects to such amendment in writing within fifteen (15) days of receipt of such written notice. In the event that Plan objects timely to such amendment, the Parties shall work in good faith to reach agreement on an amendment to this Addendum that complies with the final regulations. If the Parties are unable to reach agreement regarding an amendment to this Addendum within thirty (30) days of the date that Cigna receives any written objection from Plan, either Cigna or Plan Sponsor may terminate this Addendum upon ninety (90) days written notice to the other Party. Any other amendment to this Addendum unrelated to compliance with applicable law and regulations shall be effective only upon execution of a written agreement between the Parties.

Section 3. Relationship of Parties. For the purposes of this Addendum, the Parties intend that Cigna is an independent contractor and not an agent of the Plan or the Plan

Contractor's Initials YS.

Sponsor.

II. PERMITTED USES AND DISCLOSURES BY Cigna

Section 1. Uses and Disclosures Generally. Except as otherwise provided in this Addendum, Cigna may use or disclose PHI to perform functions, activities or services for, or on behalf of, the Plan as specified in the Agreement, provided that such use or disclosure would not violate the HIPAA Privacy & Security Rules if done by the Plan. Cigna shall not further use or disclose PHI other than as permitted or required by this Addendum, or as required by law.

Section 2. To Carry Out Plan Obligations. To the extent Cigna is to carry out one or more of the Plan's obligations under Subpart E of 45 C.F.R. Part 164, Cigna agrees to comply with the requirements of Subpart E that apply to the Plan in the performance of such obligations.

Section 3. Management and Administration.

(A) Cigna may use PHI for the proper management and administration of Cigna or to carry out the legal responsibilities of Cigna.

(B) Cigna may disclose PHI for the proper management and administration of Cigna, provided that disclosures are: (a) required by law; or (b) Cigna obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it is disclosed to the person, and the person notifies Cigna of any instances of which it is aware in which the confidentiality of the information has been breached.

(C) Cigna may use or disclose PHI to provide Data Aggregation services relating to the Health Care Operations of the Plan, or to de-identify PHI provided that it does so in accordance with HIPAA de-identification rules. Once information is de-identified, this Addendum shall not apply.

Section 4. Required or Permitted by Law. Cigna may use or disclose PHI as required by law or permitted by 45 C.F.R. §164.512.

III. OTHER OBLIGATIONS AND ACTIVITIES OF Cigna

Section 1. Receiving Remuneration in Exchange for PHI Prohibited. Cigna shall not directly or indirectly receive remuneration in exchange for any PHI of an Individual, unless an authorization is obtained from the Individual. in accordance with 45 C.F.R. §164.508,

Contractor's Initials YS

that specifies whether PHI can be exchanged for remuneration by the entity receiving PHI of that individual, unless otherwise permitted under the HIPAA Privacy Rule.

Section 2. Limited Data Set or Minimum Necessary Standard and Determination. Cigna shall, to the extent practicable, limit its use, disclosure or request of Individuals' PHI to the minimum necessary amount of Individuals' PHI to accomplish the intended purpose of such use, disclosure or request and to perform its obligations under the underlying Agreement and this Addendum. Cigna shall determine what constitutes the minimum necessary to accomplish the intended purpose of such disclosure.

Section 3. Security Standards. Cigna shall use appropriate safeguards and comply with Subpart C of 45 C.F.R. Part 164 with respect to Electronic PHI to prevent use or disclosure of PHI other than as provided for by the Agreement.

Section 4. Protection of Electronic PHI. With respect to Electronic PHI, Cigna shall:

(A) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that Cigna creates, receives, maintains or transmits on behalf of the Plan as required by the Security Standards; and

(B) Ensure that any agent or subcontractor to whom Cigna provides Electronic PHI agrees to implement reasonable and appropriate safeguards to protect such information.

Section 5. Reporting of Violations. Cigna shall report to the Plan any use or disclosure of PHI not provided for by this Addendum of which it becomes aware, including a Breach or Security Incident. Cigna agrees to mitigate, to the extent practicable, any harmful effect from a use or disclosure of PHI in violation of this Addendum of which it is aware. The Parties agree that such reports are not required for trivial and routine incidents such as port scans, attempts to log-in with an invalid password or user name, denial of service attacks that do not result in a server being taken off-line, malware and pings or other similar types of events.

Section 6. Breach Notification. Cigna will notify the Plan of a Breach (including privacy related incidents that might, upon further investigation, be deemed to be a Breach) without unreasonable delay in accordance with 45 C.F.R. §164.410 after Cigna's discovery of same. This notification will include, to the extent known:

i. the names of the individuals whose PHI was involved in the Breach;

ii. the circumstances surrounding the Breachh;

Contractor's Initials Y.S.

iii. the date of the Breach and the date of its discovery;

iv. the information Breached;

v. any steps the impacted individuals should take to protect themselves;

vi. the steps Cigna is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and,

vii. a contact person who can provide additional information about the Breach.

For purposes of discovery and reporting of Breaches, Cigna is not the agent of the Plan or the Employer (as "agent" is defined under common law). Cigna will investigate Breaches, assess their impact under applicable state and federal law and make a recommendation to the Plan as to whether notification is required pursuant to 45 C.F.R. §§164.404-408 and/or applicable state breach notification laws. Upon Plan's written request, Cigna will issue notices to such individuals, state and federal agencies – including the Department of Health and Human Services, and/or the media – as the Plan is required to notify pursuant to, and in accordance with the requirements of applicable law (including 45 C.F.R. §§164.404-408). In the event of a Breach affecting multiple Cigna clients where Cigna believes notification to affected individuals is required in accordance with applicable law, Cigna reserves the right to issue notifications to the affected individuals without Plan approval.

Cigna will pay the costs of issuing notices required by law and other remediation and mitigation which, in Cigna's discretion, are appropriate and necessary to address the Breach. Cigna will not be required to issue notifications that are not mandated by applicable law. Cigna shall provide the Plan with information necessary for the Plan to fulfill its obligation to report Breaches affecting fewer than 500 Individuals to the Secretary as required by 45 C.F.R. §164.408(c).

Section 7. Disclosures to and Agreements with Third Parties. Cigna agrees to ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of Cigna agree to the same restrictions, conditions and requirements that apply to Cigna with respect to such information.

Section 8. Access to PHI. Cigna shall provide an Individual with access to such Individual's PHI contained in a Designated Record Set in response to such Individual's request in the time and manner required in 45 C.F.R. §164.524.

Section 9. Availability of PHI for Amendment. Cigna shall respond to a request by an Individual for amendment to such Individual's PHI contained in a Designated Record Set in the time and manner required in 45 C.F.R. §164.526.

Contractor's Initials YS.

Section 10. Right to Confidential Communications and to Request Restriction of Disclosures of PHI. Cigna shall respond to a request by an Individual for confidential communications or to restrict the uses and disclosures of PHI contained in such Individual's Designated Record Set in the time and manner required by 45 C.F.R. §164.522. Cigna shall not be obligated to agree to, or implement, any restriction, if such restriction would hinder Health Care Operations or the provision of the functions, activities or services, unless such restriction would otherwise be required by 45 C.F.R. § 164.522(a).

Section 11. Accounting of PHI Disclosures. Cigna shall provide an accounting of disclosures of PHI to an Individual who requests such accounting in the time and manner required in 45 C.F.R. §164.528.

Section 12. Availability of Books and Records. Cigna hereby agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by Cigna on behalf of the Plan, available to the Secretary for purposes of determining the Plan's compliance with the Privacy Rule.

Section 13. Standard Transactions. Cigna certifies that it conducts any applicable transactions that are subject to the HIPAA standard transaction rules (45 C.F.R. Parts 160-164) as required under such rules.

IV. TERMINATION OF AGREEMENT WITH Cigna

Section 1. Termination Upon Breach of Provisions Applicable to PHI. Any other provision of the Agreement notwithstanding, upon either Party's knowledge of a material breach by the other of this Addendum, the non-breaching Party shall notify the breaching Party of such material breach and the breaching Party shall have thirty (30) days to cure such material breach. In the event the breach is not cured, or the cure is infeasible, the non-breaching Party shall have the right to immediately terminate this Addendum and the Agreement or if the cure of the material breach is infeasible, report the violation to the Secretary.

Section 2. Use and Disclosure of PHI upon Termination. The Parties hereto agree that it is not feasible for Cigna to return or destroy PHI at termination of the Agreement; therefore, the protections of this Addendum for PHI shall survive termination of the Agreement, and Cigna shall limit any further uses and disclosures of such PHI to the purpose or purposes which make the return or destruction of such PHI infeasible.

Contractor's Initials YS

V. OBLIGATIONS OF THE PLAN AND PLAN SPONSOR

Section 1. Disclosures Generally. Except as otherwise provided for in this Addendum, the Plan will not request that Cigna use or disclose PHI in any manner that would not be permissible under HIPAA.

Section 2. Disclosures to the Plan or Third Parties. To the extent the Plan requests that Cigna disclose PHI either to the Plan or to a third party business associate acting for the Plan, the Plan represents and warrants that:

(A) It only will request PHI for the purposes of Treatment, Payment, or Health Care Operations, or another permitted purpose under the HIPAA Privacy Rule;

(B) The information requested is the minimum necessary to achieve the purpose of the disclosure; and

(C) If the PHI is to be disclosed to a third party, the Plan has a business associate agreement in place with the third party.

Section 3. Disclosure to Plan Sponsor. To the extent the Plan requests that Cigna disclose PHI to the Plan Sponsor, the Plan and Plan Sponsor each represent and warrant that:

(A) The information only will be used for one of the following purposes:

i. Plan Administration functions, as defined by the HIPAA Privacy Rule, and that the Plan Sponsor has executed the required plan amendment and certification allowing the disclosure, as set out in the HIPAA Privacy Rule;

ii. Enrollment functions, provided the information to be disclosed is limited to enrollment and disenrollment information; or

iii. To amend, modify, or terminate the Plan, or to obtain premium bids to provide health insurance coverage under the Plan, provided the information to be disclosed is limited to Summary Health Information, as defined in the HIPAA Privacy Rule; and

(B) The information requested is the minimum necessary to achieve the purpose of the disclosure.

VI. DEFINITIONS FOR USE IN THIS ADDENDUM

Definitions. Certain capitalized terms used in this Addendum shall have the meanings ascribed to them by HIPAA including their respective implementing regulations and guidance. If the meaning of any term defined herein is changed by regulatory or legislative amendment, then this Addendum will be modified automatically to correspond to the

Contractor's Initials Y.S.

amended definition. All capitalized terms used herein that are not otherwise defined have the meanings described in HIPAA. A reference in this Addendum to a section in the HIPAA Privacy Rule or HIPAA Security Rule means the section then in effect, as amended.

"Breach" shall have the same meaning as the term "breach" in 45 C.F.R. § 164.402.

"Business Associate" means Cigna.

"Covered Entity" means the Plan.

"Designated Record Set" shall have the same meaning as the term "designated record set" in 45 C.F.R. § 164.501.

"Electronic Protected Health Information" shall mean PHI that is transmitted by, or maintained in, electronic media as that term is defined in 45 C.F.R. §160.103, limited to the information created or received by Cigna from or on behalf of Plan.

"Limited Data Set" shall have the same meaning as the term "limited data set" as set forth in 45 C.F.R. §164.514(e)(2).

"Protected Health Information" or **"PHI"** shall have the same meaning as set forth at 45 C.F.R. §160.103.

"Secretary" shall mean the Secretary of the United States Department of Health and Human Services.

"Security Incident" shall have the same meaning as the term "security incident" as set forth in 45 C.F.R. §164.304.

"Unsecured Protected Health Information" shall have the same meaning as the term "unsecured protected health information" in 45 C.F.R. § 164.402.

Contractor's Initials YS.

Contractor's Initials Y.S.

HEALTHSPRING LIFE & HEALTH INSURANCE COMPANY, INC.
CIGNA HEALTH AND LIFE INSURANCE COMPANY
EVERNORTH DIRECT HEALTH, LLC

SECRETARY'S CERTIFICATE

The undersigned, a duly elected Assistant Secretary of HealthSpring Life & Health Insurance Company, Inc. ("HSL&H"), Cigna Health and Life Insurance Company ("CHLIC") and Evernorth Direct Health, LLC ("EDH"), does hereby represent and certify that the following resolutions were adopted by the Board of Directors of HSL&H on March 27, 2023, CHLIC on March, 23, 2023 and by the Sole Manager of EDH on February 20, 2023 and that such resolutions remains in full force and effect as of the date hereof, not having been amended, modified or rescinded since the date of its adoption:

RFP Signature Authorization

RESOLVED, that any officer of the Company or person holding the title of Regional Growth Leader, Market Growth Leader, or President of Government & Education for the Company or any of its subsidiaries or affiliates is hereby authorized to enter into and sign requests for proposal responses and any related documents on behalf of the Company.

It is hereby further certified that Yesenia Sanchez is a Vice President of CHLIC having been elected by the Board of Directors on June 28, 2021.

It is hereby further certified that Yesenia Sanchez holds the business title of Market Growth Leader for HSL&H and EDH or any subsidiaries or affiliates related thereto and is authorized to enter into and sign documentation as an Authorized Signatory as set forth in the aforementioned resolution.

IN WITNESS WHEREOF, I hereunto set my hand on this 29th day of March, 2023.

Susan M. Metrow
Susan M. Metrow, Assistant Secretary

Company #: 1115867

GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES

OFFICE OF THE LIEUTENANT GOVERNOR

Division of Banking, Insurance, and Financial Regulation

Certificate of Authority

This is to certify that in accordance with the Virgin Islands Code, which provides for the regulation of the business of Insurance in the Virgin Islands,

CIGNA Health and Life Insurance Company

900 Cottage Grove Road Bloomfield CT 06002

having filed all the documents required by law and having otherwise complied with the applicable insurance laws of the U.S. Virgin Islands is hereby authorized to transact the type(s) of insurance listed below:

Life
Accident
Health
Annuities

NOW, THEREFORE, I **Tregenza A. Roach Esq.** Lieutenant Governor and Commissioner of Insurance, pursuant to the authority vested in me in Section 209 of the Title 22 Virgin Islands Code, hereby issue this Certificate Of Authority which authorizes said Company to transact the type(s) of insurance set forth above.

This certificate is valid from January 01, 2023 to December 31, 2023. Renewal of this Certificate is required annually upon expiration on the 31st day of December, and it may be suspended or revoked as provided in Section 212 of Title 22 Virgin Islands Code.

Given under the Seal of the Government of the Virgin Islands of the United States, at Charlotte Amalie, St. Thomas.

Tregenza A. Roach

TREGENZA A. ROACH ESQ.
Lieutenant Governor / Insurance Commissioner

GOVERNMENT OF
THE VIRGIN ISLANDS OF THE UNITED STATES
GESC/HEALTH INSURANCE
BOARD OF TRUSTEES
P.O. Box 11177
St. Thomas, Virgin Islands 00801

August 28, 2023

Honorable Albert Bryan Jr.
Governor of the Virgin Islands
Government House
Nos. 21-22 Kongens Gade
St. Thomas, VI 00802

RE: Justification Letter – GESC/Health Insurance Board of Trustees Medical Coverage effective October 1, 2023

Dear Governor Bryan:

The Government Employees Service Commission (GESC) Health Insurance Board of Trustees ("Board") acting as the sole body overseeing the operation of the Government employees' health and other benefit plans, has recently completed a Request for Proposals (RFP) for competitive bids as required by statute for insurance services which included Medical and Prescription Drug coverage for active employees and retirees, Employee Assistance Program, Dental, Vision, Life and Accidental Death & Dismemberment (AD&D) plans.

The RFP was released on March 15, 2023, and bids were received through April 24, 2023. Advertisements were released nationally and also in the St. Croix, St. John, and St. Thomas Source publications from March 15 through April 14, 2023.

Through the RFP process, the Board received two (2) responses for medical and prescription drug insurance for both active employees and the under 65 retiree population, two (2) responses for dental insurance, one (1) response for vision insurance, and three (3) responses for life and AD&D insurance.

The RFP evaluations were reviewed at the Board's May meeting and finalist meetings were held in-person at the Board's meeting in June.

Based upon the most recent medical claims experience report through July 2023, the medical claims expenditures are 90% of the medical plans' premiums, exclusive of other plan expenditures such as administrative costs. This has increased from the prior year. Although the losses have increased 4.4% from the prior period, the Board was anticipating a 5-8% increase in premiums to cover future claims and expenses based upon an analysis by our Consultant, Gehring Group.

We received two responses for our medical coverage for active employees and pre-65 retirees. One from Cigna Healthcare (incumbent) and one from UnitedHealthcare. Cigna's initial response was a no increase in premiums and no changes to the current benefits. UnitedHealthcare proposed a 2% increase in premiums while matching the existing benefits. Subsequently, Cigna offered a premium rate cap for year 2 of the contract not-to-exceed 8% while United provided a not-to-exceed of 12%.

After finalist presentations the Board voted unanimously to begin contract negotiations with Cigna Healthcare.

Since the premiums will remain the same for the upcoming fiscal year the overall impact to the Central Government will be approximately $107 million based upon the existing cost-share with employees and retirees.

It was vital to the Board that there were no plan design changes (i.e., increasing copayments, deductibles, out-of-pocket maximums) due to the current state of the economy and Cigna agreed to not change any of the benefits, nor did they decrease the level of services that are offered with the current plan.

In addition to the above financial implications, Cigna will continue to include and enhance the following in their contract with the Board:

- Support the USVI community by providing six (6) two-year nursing scholarships to the University of the Virgin Islands in the amount of $6,250 per student per year and providing $375,000 in grants to non-profit agencies;
- Provide a Wellness Funds of $1,000,000 (currently $700,000);
- Continuation of the two (2) full time on-site Customer Service Representatives;
- Inclusion of MotivateMe, a turnkey wellness incentive program that gives employees and their spouses opportunities to earn rewards for taking charge of and improving their health while funding $300,000 in incentives;
- Continuation of Omada's Pre-Diabetes Prevention Program;
- Continuation of the 2 Health Improvement Offices with two (2) health coaches and two (2) mobile vans;
- Placing $1.7 in premiums at risk for performance guarantees; and
- The Cigna Foundation will be offering $250,000 in grants over the next three years to non-profits in the Territory helping those living with obesity, high blood pressure, diabetes, and other chronic conditions with the goal of improving their overall health.

The Board believes it was able to negotiate the overall lowest cost for both the Government, and its employees and retirees, all while maintaining a viable benefit offering.

Sincerely,

Beverly A. Joseph
Chairperson, GESC/Health Insurance Board of Trustees

pc: GESC Health Insurance Board Members
Cindy Richardson, Director of Personnel
Valerie Clarke-Daley, Chief, Group Health Insurance
Ian S.A. Clement, Assistant Attorney General, Solicitor General Division
Gehring Group Consultant

Government of The Virgin Islands of the United States
Central Government & GERS Group Health Projected Budget
Fiscal Year: October 1, 2023 - September 30, 2024

GEHRING GROUP
A RISK STRATEGIES COMPANY

Plan	Coverage Type	Enrollment	2022-2023 Estimated FY Total Premium	2022-2023 Estimated FY Employer Share	2022-2023 Estimated FY Employee Share	2023-2024 Projected FY Total Premium	2023-2024 Projected FY Employer Share	2023-2024 Projected FY Employee Share
Active Employees								
Medical	Employee	3,307	$ 38,214,898	$ 27,896,876	$ 10,318,023	$ 38,214,898	$ 27,896,876	$ 10,318,023
	Family	3,755	$ 75,873,830	$ 55,387,896	$ 20,485,934	$ 75,873,830	$ 55,387,896	$ 20,485,934
Dental	Employee	3,307	$ 786,537	$ 589,903	$ 196,634	$ 786,537	$ 589,903	$ 196,634
	Family	3,722	$ 2,258,212	$ 1,693,659	$ 564,553	$ 2,258,212	$ 1,693,659	$ 564,553
Life	Basic	7,848	$ 170,459	$ 170,459	$ -	$ 95,118	$ 95,118	$ -
	Voluntary	5,827	$ 2,123,357	$ -	$ 2,123,357	$ 2,123,357	$ -	$ 2,123,357
	Spouse	1,198	$ 115,473	$ -	$ 115,473	$ 115,473	$ -	$ 115,473
	Child(ren)	2,610	$ 20,984	$ -	$ 20,984	$ 20,984	$ -	$ 20,984
Vision	Employee	5,154	$ 244,918	$ -	$ 244,918	$ 244,918	$ -	$ 244,918
	Family	3,721	$ 466,167	$ -	$ 466,167	$ 466,167	$ -	$ 466,167
TOTAL - Active Employees			**$ 120,274,835**	**$ 85,738,792**	**$ 34,536,043**	**$ 120,199,495**	**$ 85,663,451**	**$ 34,536,043**
$ Amount Increase/(Decrease)						**$ (75,341)**	**$ (75,341)**	**$ -**
% Amount Increase/(Decrease)						**-0.1%**	**-0.1%**	**0.0%**
Retirees								
Under 65 Medical	Retiree	773	$ 11,581,272	$ 8,454,328	$ 3,126,943	$ 11,581,272	$ 8,454,328	$ 3,126,943
	Retiree Dependents	374	$ 5,603,358	$ 4,090,451	$ 1,512,907	$ 5,603,358	$ 4,090,451	$ 1,512,907
	Family	577	$ 15,450,768	$ 11,279,060	$ 4,171,707	$ 15,450,768	$ 11,279,060	$ 4,171,707
Over 65 Medical	Medicare Advantage	6,513	$ 19,557,757	$ 12,908,120	$ 6,649,638	$ 19,557,757	$ 12,908,120	$ 6,649,638
Dental	Retiree	4,874	$ 1,159,198	$ 869,399	$ 289,800	$ 1,159,198	$ 869,399	$ 289,800
	Family	1,900	$ 1,152,595	$ 864,446	$ 288,149	$ 1,152,595	$ 864,446	$ 288,149
Life	Basic	8,242	$ 659,195	$ 659,195	$ -	$ 331,328	$ 331,328	$ -
	Voluntary	6,466	$ 7,017,974	$ -	$ 7,017,974	$ 7,017,974	$ -	$ 7,017,974
	Spouse	1,428	$ 563,825	$ -	$ 563,825	$ 563,825	$ -	$ 563,825
	Child(ren)	485	$ 3,899	$ -	$ 3,899	$ 3,899	$ -	$ 3,899
Vision	Retiree	1,061	$ 50,419	$ -	$ 50,419	$ 50,419	$ -	$ 50,419
	Family	346	$ 43,347	$ -	$ 43,347	$ 43,347	$ -	$ 43,347
TOTAL - Retirees			**$ 62,843,606**	**$ 39,124,999**	**$ 23,718,607**	**$ 62,515,739**	**$ 38,797,133**	**$ 23,718,607**
$ Amount Increase/(Decrease)						**$ (327,867)**	**$ (327,867)**	**$ -**
% Amount Increase/(Decrease)						**-0.5%**	**-0.8%**	**0.0%**
TOTAL - Active Employees & Retirees			$ 183,118,442	$ 124,863,791	$ 58,254,650	$ 182,715,234	$ 124,460,584	$ 58,254,650
$ Amount Increase/(Decrease)						$ (403,208)	$ (403,208)	$ -
% Amount Increase/(Decrease)						-0.2%	-0.3%	0.0%

Notes:

A. Projected Budget assumes Actual Premium Rates Negotiated in GESC RFP No. 2023-01.

B. Over 65 Medical is 9-months of the fiscal year (effective January 1, 2024).

1. Estimated FY Total Premium may vary based upon actual enrollment for the remainder of current Fiscal Year & proposed Fiscal Year.

2. Costs account for Senate funded subsidies of member contributions for FY2019-2020; FY2020-2021; FY2021-2022; & FY2022-2023.

BENEFIT SUMMARY

Cigna Health and Life Insurance Co.
For - The Government of the US Virgin Islands
Open Access Plus Plan
OAP Plan
Effective - 10/01/2023

Selection of a Primary Care Provider - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

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

Behavioral Health for NM residents - No Charge for in-network state mandated mental health, behavioral or substance use disorder diagnoses.

A notice for Missouri residents required by RSMo 376.1199.6: This plan has purchased an optional rider to cover elective abortions. The enrollee has the right to exclude, and not pay for, coverage for elective abortions if such coverage is contrary to the enrollee's moral, ethical or religious beliefs.

A notice for Oklahoma residents per 63 Okl. St. § 1-741.3: This plan has purchased an optional rider to cover elective abortions. The enrollee has the right to exclude from their plan, and not pay for, coverage for elective abortions.

A notice for Texas residents per Tex. Ins. Code §1218.001 et.al.: This plan has purchased an optional rider to cover elective abortions. The enrollee has the right to exclude from their plan, and not pay for, coverage for elective abortions.

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.	
Plan Coinsurance	Plan pays 80%	Plan pays 60%
Maximum Reimbursable Charge	Not Applicable	150%

Plan Highlights	In-Network	Out-of-Network
Plan Deductible	Individual: $500 Family: $1,000	Individual: $1,000 Family: $2,000

- Only the amount you pay for in-network covered expenses counts towards your in-network deductible. Only the amount you pay for out-of-network covered expenses counts towards your out-of-network deductible.
- Benefit copays/deductibles always apply before plan deductible and coinsurance.
- Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.

Note: Services where plan deductible applies are noted with a caret (^).

Plan Out-of-Pocket Maximum	Individual: $5,000 Family: $10,000	Individual: $10,000 Family: $20,000

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.
- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Physician Services - Office Visits		
Primary Care Physician (PCP) Services/Office Visit	$20 copay, and plan pays 100%	Plan pays 60% ^
Specialty Care Physician Services/Office Visit	$30 copay, and plan pays 100%	Plan pays 60% ^
NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Allergy Treatment/Injections and Allergy Serum Allergy serum dispensed by the physician in the office **Note:** Office copay does not apply if only the allergy serum is provided.	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Preventive Care		
Preventive Care	Plan pays 100%	Not Covered

- Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.
- Annual Limit: Unlimited

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Immunizations	Plan pays 100%	Not Covered
PAP • Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service. • Associated wellness exam is covered in-network only.	Plan pays 100%	Covered same as other x-ray and lab services, based on Place of Service
Mammogram and PSA Tests • Preventive and Diagnostic including Professional Services.	Plan pays 100%	Covered same as other x-ray and lab services, based on Place of Service
Inpatient		
Inpatient Hospital Facility Services **Note:** Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs	$100 per admission copay, and plan pays 80% ^	$100 per admission deductible, and plan pays 60% ^
Inpatient Hospital Physician's Visit/Consultation	Plan pays 80% ^	Plan pays 60% ^
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 80% ^	Plan pays 60% ^
Outpatient		
Outpatient Facility Services	Plan pays 80% ^	Plan pays 60% ^
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 80% ^	Plan pays 60% ^
Emergency Services		
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. • Per visit copay is waived if admitted.	$50 copay, and plan pays 80% ^	$50 copay, and plan pays 80% ^
Urgent Care Facility • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	Plan pays 80% ^	Plan pays 80% ^
Ambulance Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 80% ^	Plan pays 80% ^
Inpatient Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 120 days	Plan pays 80% ^	Plan pays 60% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Laboratory Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 80% ^	Plan pays 60% ^
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Radiology Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Physician's Services/Office Visit	Plan pays 80% ^	Covered same as Physician Services - Office Visit
Outpatient Therapy Services		
Outpatient Therapy and Chiropractic Services	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Annual Limits: • All Therapies Combined - Includes Chiropractic Care, Cardiac Rehabilitation, Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - 60 days • Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.		
Hospice		
Inpatient Facilities	Plan pays 80% ^	Plan pays 60% ^
Outpatient Services	Plan pays 80% ^	Plan pays 60% ^
Note: Includes Bereavement counseling provided as part of a hospice program.		
Bereavement Counseling (for services not provided as part of a hospice program)		
Services Provided by a Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Medical Specialty Drugs		
Outpatient Facility	Plan pays 80% ^	Plan pays 60% ^
Physician's Office	Plan pays 100%	Plan pays 60% ^
Home	Plan pays 80% ^	Plan pays 60% ^
Note: This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.		
Maternity		
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 80% ^	Plan pays 60% ^
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
Delivery - Facility (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Abortion		
Abortion Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Note: Elective and non-elective procedures		
Family Planning		
Women's Services	Plan pays 100%	Coverage varies based on Place of Service
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)		
Men's Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
Infertility		
Infertility Treatment	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment and excludes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Other Health Care Facilities/Services		
Home Health Care • Annual Limit: 40 days (The limit is not applicable to mental health and substance use disorder conditions.) • 16 hour maximum per day	Plan pays 80% ^	Plan pays 60% ^
Private Duty Nurse • Outpatient and Inpatient • Annual Limit: Unlimited	Plan pays 80% ^	Plan pays 60% ^
Organ Transplants		
Inpatient Hospital Facility Services		
LifeSOURCE Facility	$100 per admission copay, and plan pays 100%	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
Inpatient Professional Services		
LifeSOURCE Facility	Plan pays 100%	Not Applicable
Non-LifeSOURCE Facility	Covered same as plan's Inpatient Professional benefit	Covered same as plan's Inpatient Professional benefit
• Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant per Lifetime		
Durable Medical Equipment • Annual Limit: Unlimited	Plan pays 80% ^	Plan pays 60% ^
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan pays 100%	Plan pays 60% ^
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	Plan pays 80% ^	Plan pays 60% ^
Temporomandibular Joint Disorder (TMJ) • Unlimited lifetime maximum	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Note: Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.		
Bariatric Surgery • Unlimited lifetime limit	Coverage varies based on Place of Service	Not Covered
Treatment of Clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity • weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision		
Routine Foot Care	Not Covered	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.		
Hearing Aids • Annual Limit: Unlimited • Maximum of 2 devices (one per ear) per 36 months • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share • Coverage through age 20	Plan pays 80% ^	Plan pays 60% ^
Mental Health and Substance Use Disorder		
Inpatient Mental Health	$100 per admission copay, and plan pays 80% ^	$100 per admission deductible, and plan pays 60% ^
Outpatient Mental Health – Physician's Office	Plan pays 100%	Plan pays 60% ^
Outpatient Mental Health – All Other Services	Plan pays 100%	Plan pays 60% ^
Inpatient Substance Use Disorder	$100 per admission copay, and plan pays 80% ^	$100 per admission deductible, and plan pays 60% ^
Outpatient Substance Use Disorder – Physician's Office	Plan pays 100%	Plan pays 60% ^
Outpatient Substance Use Disorder – All Other Services	Plan pays 100%	Plan pays 60% ^
Annual Limits: • Unlimited maximum <u>Notes:</u> • Inpatient includes Acute Inpatient and Residential Treatment. • Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc. • Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services and Applied Behavior Analysis (ABA Therapy), etc. • Services are paid at 100% after you reach your out-of-pocket maximum.		
Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs **Inpatient and Outpatient Management** • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs • Narcotic Therapy Management • inMynd℠ program - a comprehensive, holistic solution to help recognize and find resources to treat behavioral health conditions.		

Pharmacy	In-Network	Out-of-Network
Cost Share and Supply		
Cigna Pharmacy Cost Share • Retail – up to 30-day supply • Home Delivery – up to 90-day supply	**Retail (per 30-day supply):** Generic: You pay $10 Preferred Brand: You pay $20 Non-Preferred Brand: You pay 50% subject to a minimum of $40 and a maximum of $100 **Home Delivery (per 90-day supply):** Generic: You pay $20 Preferred Brand: You pay $40 Non-Preferred Brand: You pay 50% subject to a minimum of $80 and a maximum of $200	**Retail:** Generic: You pay 50% Preferred Brand: You pay 50% Non-Preferred Brand: You pay 50% subject to a minimum of $40 **Home Delivery:** Not Covered

- Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- If a generic is available, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.

For Delaware and Vermont residents:

For prescription drug plans that include a mail order drug plan (home delivery), the copayment for a 90-day supply at retail or mail order pharmacies will be equal to three times the copayment for a 30-day supply. The copayment for a 90-day supply when obtained from either a retail or mail order drug pharmacy will be equal. The mail order drug plan coinsurance level for a 90-day supply will be the same as the retail coinsurance level. Each prescription order or refill will be limited to up to a consecutive 90-day supply at a mail order or retail participating pharmacy, unless limited by the drug manufacturer's packaging or other applicable law.

Drugs Covered

Prescription Drug List:
Your Cigna Standard Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.
Some highlights:

- Coverage includes Self Administered injectables and optional injectable drugs – but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.
- Prescription weight loss drugs are covered.

Pharmacy Program Information

Pharmacy Clinical Management

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements
- Quantity over time edits and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

Additional Information

Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Cigna Diabetes Prevention Program in collaboration with Omada

Cigna Diabetes Prevention Program in collaboration with Omada is a program to help you avoid the onset of diabetes, as well as health risks that might lead to heart disease or a stroke. The program is covered by your health plan at the preventive level, just like for your wellness visit. Program participants have access to a professional virtual health coach, an online support group, interactive lessons, and a smart-technology scale. The program will help you make small changes in your eating, activity, sleep, and stress to achieve healthy weight loss through a series of 16 weekly lessons and tools to help you maintain weight loss over time. You will also be offered the opportunity to join a gym for a low monthly fee and no enrollment fee.

Healthy Pregnancies/Healthy Babies • Care Management outreach • Maternity Case Management • Neo-natal Case Management	$250 (1st trimester) / $125 (2nd trimester) - Option 2

Additional Information

Maximum Reimbursable Charge
The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (150%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. 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. Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

Out-of-Network Emergency Services Charges
1. Emergency Services are covered at the In-Network cost-sharing level as required by applicable state or federal law if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

Medicare Coordination
In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

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.

One Guide
Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

Additional Information

Pre-Certification - Continued Stay Review - Preferred Care Management Inpatient - required for all inpatient admissions
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 50% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

Pre-Certification - Preferred Care Management Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 50% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

Pre-Existing Condition Limitation (PCL) does not apply.

Your Health First - 300
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Place of Service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
    - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
    - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;

Exclusions

  - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.
  - In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: acupressure; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- For eligible dependent children (under age 18 or until age 21 if still in high school), hearing aids must be covered up to $2,200 per hearing aid per ear every 36 months.
- Hearing aids, except as shown in the Schedule, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored

Exclusions

Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.

- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for phenylketonuria (PKU) infant formula needed for the treatment of inborn errors of metabolism.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a non-Participating Provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a non-Participating Provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Massage therapy.

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate, service agreement or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

EHB State: VI

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

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

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

Cigna

Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

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

896375b 05/21

Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CERTIFICATE OF REDOMESTICATION

INSURANCE COMPANY REDOMESTICATION TO CONNECTICUT

Office of the Secretary of the State

MAILING ADDRESS:
Commercial Recording Division
Connecticut Secretary of the State
P.O. Box 150470
Hartford, CT 06115-0470
860-509-6003

DELIVERY ADDRESS:
Commercial Recording Division
Connecticut Secretary of the State
30 Trinity Street
Hartford, CT 06106
860-509-6003

Certificate of Authorization from Insurance Commissioner and a certified copy of the original Articles of Incorporation must be filed with this certificate.

FEE: $100.00 *(plus franchise tax)*

Space For Office Use Only | **Make Checks Payable To "Secretary of the State"**

FILING #0004114403 PG 01 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02807
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

1. NAME OF INSURANCE COMPANY:

Alta Health & Life Insurance Company

2. CHARTER HISTORY OF CORPORATION (including date and place of incorporation, name change information and information regarding change of domicile state):

The corporation was originally incorporated on May 2, 1963 as "Orange State Life Insurance Company" under the laws of the State of Florida. On June 15, 1982, the corporation's name was changed to "Home Life Financial Assurance Corporation." On August 1, 1994, the corporation transferred its state of domicile from the State of Florida to the State of Ohio. On March 21, 1996, the corporation changed its corporate name to "Anthem Health & Life Insurance Company" and it transferred its state of domicile from the State of Ohio to the State of Indiana. On July 19, 1999, the corporation's name was changed to "Alta Health & Life Insurance Company."

3. APPROVALS:

The corporation's redomestication to Connecticut was approved by the Insurance Commissioner of the State of

Indiana

(State from which corporation is redomesticating)

The corporation's redomestication was approved by the Insurance Commissioner of the State of Connecticut as demonstrated by such Commissioner's Certificate of Approval included herewith.

(Please reference an 8 1/2 X 11 attachment if additional space is needed)

Space For Office Use Only

FILING #0004114403 PG 02 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02808
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

4. VOTE INFORMATION (check and complete A. or B.):

X A. The insurance company has authority to issue capital stock. The resolution of redomestication was adopted by its board of directors and approved by its shareholders as follows (provide at minimum the total number of shareholder votes cast in favor of the resolution and the total number of votes cast against the resolution or if no shareholder approval was required, provide a statement to that effect):

The board of directors of the corporation, acting by unanimous written consent, duly adopted resolutions approving the redomestication. The sole shareholder of the corporation, also acting by unanimous written consent, duly approved the redomestication

____ B. The corporation is a mutual insurance company. The resolution of redomestication was adopted by its board of directors and approved by its members as follows (provide at minimum the total number of member votes cast in favor of the resolution and the total number of votes cast against the resolution or if no membership approval was required, provide a statement to that effect):

5. CERTIFICATE OF INCORPORATION:

The corporation's amended and restated Certificate of Incorporation is attached hereto.

6. EXECUTION:

Signed this 4th day of March, 2010.

Shermona Mapp	Corporate Secretary	
Print or type name of signatory	Capacity of signatory	Signature

Rev. 12/07/06

FILING #0004114403 PG 03 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02809
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

AMENDED AND RESTATED ARTICLES OF INCORPORATION

OF

ALTA HEALTH AND LIFE INSURANCE COMPANY

SECTION 1. The new name of the corporation shall be CIGNA Health and Life Insurance Company.

SECTION 2. In accordance with Connecticut General Statutes Section 38a-58a, the corporation shall adopt the State of Connecticut as its corporate domicile and shall be subject to the authority and jurisdiction of the State of Connecticut, with all the powers granted by the general statutes, as now enacted or hereafter amended, to corporations formed under the Connecticut Business Corporation Act. The corporation shall be a continuation of the body corporate incorporated in the State of Florida on May 2, 1963. The corporation shall continue to use May 2, 1963 as the date of incorporation.

SECTION 3. The business of the corporation shall be life insurance, endowments, annuities, accident insurance, health insurance and any other business or type of business which any other corporation now or hereafter chartered by Connecticut and empowered to do a health or life insurance business may now or hereafter lawfully do. The corporation is specifically empowered to accept and to cede reinsurance and retrocession of any such risks or hazards. The corporation may exercise such powers outside of Connecticut to the extent permitted by the laws of the particular jurisdiction. Policies or other contracts may be issued stipulated to be with or without participation in profits and with or without a seal.

SECTION 4. The corporation shall be authorized to issue 2,000,000 shares of common stock with a par value of two dollars ($2) per share. The capital stock of the corporation shall be transferable in accordance with the bylaws and a transfer agent may be employed.

SECTION 5. The annual meeting of the shareholders of the corporation shall be held at such time and place as may be determined from time to time either by or in accordance with the bylaws. If the corporation shall fail to hold its annual meeting at the time specified for the meeting in any year or shall fail to elect directors thereat, the corporation shall not be dissolved nor shall its rights be impaired thereby, but a special meeting of the shareholders shall be called; and at such meeting directors to fill the places of the directors whose terms shall have expired may be elected and any other proper business may be transacted. At all meetings of the shareholders each shareholder shall be entitled to vote in person or by an attorney duly authorized by a written proxy, and each share of stock represented at the meeting shall be entitled to one vote.

SECTION 6. The corporation's principal place of business shall be at 900 Cottage Grove Road, Bloomfield, Connecticut 06152, or at some other place within the State of Connecticut, and the corporation may establish and maintain other offices and agencies in other locations within or without the State. The property and affairs of the corporation shall be managed under the direction of a board of directors. The directors shall have concurrent power with the stockholders to make, alter, amend, change, add to or repeal the bylaws of the corporation. The number of directors of the corporation shall be as from time to time fixed by, or in the manner provided in, the by-laws of the corporation. Directors will be elected by a plurality of the votes cast at each annual meeting of shareholders of the corporation and each director so elected shall hold office until the next annual meeting of shareholders of the corporation or until such director's successor is duly elected and qualified, or until such director's earlier death, resignation or removal. If any vacancy occurs in the board of directors, such vacancy may be filled by a majority of the remaining directors, whether or not such directors constitute a quorum, for the unexpired portion of the term, and if the number of directors is increased by vote of the board of directors between meetings of shareholders, the additional directors may be chosen by the board of directors for terms expiring with the next annual meeting thereafter. Unless the bylaws provide for a lesser or greater quorum as may be permitted by law, a majority of the authorized number of directors, as fixed by the board of directors from time to time, shall constitute a quorum.

SECTION 7. Connecticut General Life Insurance Company shall be the corporation's registered agent. The registered agent's address is 900 Cottage Grove Road, Bloomfield, Connecticut 06152.

SECTION 8. The personal liability of a person who is or was a director of the corporation to the corporation or its shareholders for monetary damages for breach of duty as a director shall be limited to the amount of compensation received by the director for serving the corporation during the year of the violation if such breach did not (a) involve a knowing and culpable violation of law by the director, (b) enable the director or an associate, as defined in Section 33-840 of the Connecticut Business Corporation Act as in effect on the effective date hereof or as it may be amended from time to time (the "Act"), to receive an improper personal economic gain, (c) show a lack of good faith and a conscious disregard for the duty of the director to the corporation under circumstances in which the director was aware that his conduct or omission created an unjustifiable risk of serious injury to the corporation, (d) constitute a sustained and unexcused pattern of inattention that amounted to an abdication of the director's duty to the corporation, or (e) create liability under Section 33-757 of the Act. Any lawful repeal or modification of this Section 8 or the adoption of any provision inconsistent herewith by the board of directors and the shareholders of the corporation shall not, with respect to a person who is or was a director, adversely affect any limitation of liability, right or protection existing at or prior to the effective date of such repeal, modification or adoption of a provision inconsistent herewith. The limitation of liability of any person who is or was a director provided for in this Section 8 shall not be exclusive of any other limitation or elimination of liability contained in, or which may be provided to any such person under, Connecticut law as in effect on the effective date hereof or as thereafter amended.

SECTION 9. The corporation may indemnify or advance expenses to a person who is or was a director, officer, employee or agent of the corporation, or who is or was serving at the corporation's request as a director, officer, partner, trustee, employee or agent of another corporation, a partnership, joint venture, trust, an employee benefit plan or other entity, to the extent permitted under Connecticut law as in effect on the effective date hereof or as thereafter amended, including, without limitation, pursuant to Section 33-636(b)(5) of the Act, for liability of any such person for any actions taken, or any failure to take any actions, except for conduct as set out in items (a) through (e) of Section 8, above. The corporation shall indemnify or advance expenses to any such person to the extent required by the bylaws of the corporation, as amended from time to time.

FILING #0004114405
FILED 03/05/2010 12:30 PM PAGE 02812
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

State of Connecticut

Insurance Department

This is to Certify, that

- the redomestication of Alta Health & Life Insurance Company, a Indiana Company, pursuant to Section 38a-58a Connecticut General Statutes, is approved, and

- the attached Certificate of Redomestication and Amended and Restated Articles of Incorporation effecting and name are change of domicile is approved.

Witness my hand and official seal, at HARTFORD,

this 3rd day of March, 2010

Insurance Commissioner

INDIANA SECRETARY OF STATE
BUSINESS SERVICES DIVISION
CORPORATIONS CERTIFIED COPIES

INDIANA SECRETARY OF STATE
BUSINESS SERVICES DIVISION
302 West Washington Street, Room E018
Indianapolis, IN 46204

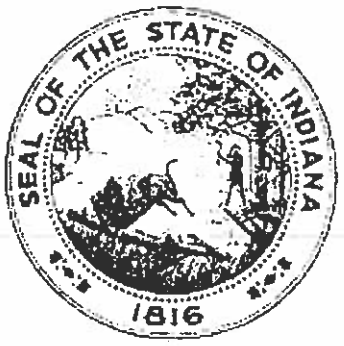
FILING #0004114403 PG 07 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02813
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

http://www.sos.in.gov

January 13, 2010

Company Requested: ALTA HEALTH & LIFE INSURANCE COMPANY
Control Number: 1996031230

Date	Transaction	# Pages
03/21/1996	Articles of Incorporation	6
03/10/1999	Miscellaneous	1
04/19/1999	Notice of Change of Registered Office or Registered Agent	2
07/19/1999	Restatement of Articles of Incorporation	6
02/13/2001	Change of Officer	1
02/13/2001	Change of Principal Address	1
02/08/2002	Administrative Dissolution	1
05/21/2002	Application of Reinstatement	3
05/22/2009	Change of Principal Address	1



State of Indiana
Office of the Secretary of State

I hereby certify that this is a true and complete copy of this 22 page document filed in this office.

Dated: January 13, 2010
Certification Number: 2010011365565

Secretary of State

Indiana Secretary of State
Packet: 1996031230
Filing Date: 03/21/1996
Effective Date: 03/21/1996

STATE OF INDIANA
OFFICE OF THE SECRETARY OF STATE

CERTIFICATE OF INCORPORATION

OF

ANTHEM HEALTH & LIFE INSURANCE COMPANY

I, SUE ANNE GILROY, Secretary of State of Indiana, hereby certify that Articles of Incorporation of the above corporation have been presented to me at my office accompanied by the fees prescribed by law; that I have found such Articles conform to law; all as prescribed by the provisions of the Indiana Business Corporation Law, as amended.

NOW, THEREFORE, I hereby issue to such corporation this Certificate of Incorporation, and further certify that its corporate existence will begin March 21, 1996.

In Witness Whereof, I have hereunto set my hand and affixed the seal of the State of Indiana, at the City of Indianapolis, this Twenty-first day of March, 1996.

Deputy

Indiana Secretary of State
Packet: 1996031230
Filing Date: 03/21/1996
Effective Date: 03/21/1996

1996031230

APPROVED
DEPARTMENT OF INSURANCE
MAR 19 1996
STATE OF INDIANA
INSURANCE COMMISSIONER

APPROVED
AND
FILED
IND. SECRETARY OF STATE

ARTICLES OF INCORPORATION AND REDOMESTICATION

OF

ANTHEM HEALTH & LIFE INSURANCE COMPANY

PREAMBLE

The undersigned corporation desires to transfer its corporate domicile from the State of Ohio to the State of Indiana pursuant to the approval of the Indiana Commissioner of Insurance and to be recognized as a corporation from its original date of incorporation of May 2, 1963 in the State of Florida.

The undersigned corporation was incorporated on May 2, 1963 under the laws of the State of Florida under the name Orange State Life Insurance Company. On June 15, 1982, the corporation's name was changed to Home Life Financial Assurance Corporation. On August 1, 1994, the corporation transferred its corporate domicile from the State of Florida to the State of Ohio.

These Articles of Incorporation and Redomestication supersede the existing Articles of Incorporation of Home Life Financial Assurance Corporation.

ARTICLE A

NAME OF THE CORPORATION

The name of the corporation is

ANTHEM HEALTH & LIFE INSURANCE COMPANY

ARTICLE B

PRINCIPAL OFFICE

The address of the Corporation's principal office in the State of Indiana is 120 Monument Circle, Indianapolis, Indiana 46204. The name of its registered agent at such address is Sandra Miller.

ARTICLE C

PURPOSES

The Corporation is organized under the Indiana Insurance Law, Chapter 162 of the Acts of 1935, as amended, and the purposes for which it is organized are:

Certification Number: 2010011365565

Indiana Secretary of State
Packet: 1996031230
Filing Date: 03/21/1996
Effective Date: 03/21/1996

To insure the lives of persons and to make every insurance appertaining thereto or connected therewith including insurance against permanent mental or physical disability resulting from accident or disease, or against accidental death combined with a policy for life insurance and to grant, purchase or dispose of annuities.

To insure against bodily injury or death by accident and against disablement resulting from sickness and every insurance appertaining thereto.

All to the extent permitted and authorized by the Department of Insurance.

ARTICLE D

TERM OF EXISTENCE

The term for which the Corporation shall continue is perpetual.

ARTICLE E

SHARES

The total number of shares which the Corporation has authority to issue is 2,000,000 shares of Common Stock (the "Common Shares") with a par value of $2.00 each.

ARTICLE F

PAID-IN CAPITAL

The amount of paid-in capital is Two Million, Five Hundred Twenty Thousand Dollars ($2,520,000).

ARTICLE G

PLAN OF BUSINESS

The business of the Corporation shall be conducted on the legal reserve stock plan.

ARTICLE H

DATA RESPECTING OFFICERS AND DIRECTORS

The names and addresses of the persons elected to serve as Officers and Directors at the time of this reinstatement and until the next Annual Meeting of the Shareholder, or until their

Certification Number: 2010011365565

successors are elected and qualify, are:

Dwane R. Houser 9842 Forestglen Drive Cincinnati, Ohio 45242	Stefen F. Brueckner 4745 Burley Hills Drive Cincinnati, Ohio 45243	William F. Milnes, Jr. 331 Sunny Acres Cincinnati, Ohio 45255
Robert C. Heird 113 Lakeview Court Loveland, Ohio 45140	James A. White 11 Ashland Court Skillman, N.J. 08558	Wayne R. Hanus 54 Green Meadow Middletown, NJ 07748
Jeremiah J. Hanrahan 161 Monroe Avenue Belle Mead, NJ 08502		

ARTICLE I

PROVISIONS FOR REGULATION OF BUSINESS AND CONDUCT OF AFFAIRS OF CORPORATION

Section I.1. The Corporation shall have the right to engage in all lines of activity allied with or incidental to the purposes for which it is formed, not forbidden by the laws of the State of Indiana, and shall have the capacity to act, the authority and all of the general rights, privileges and powers referred to in Section 80 of Chapter 162 of the Acts of 1935, as amended.

Section I.2. The number of Directors of the Corporation shall not be less than five (5) nor more than twenty-one (21), the exact number of Directors to be determined, from time to time, in such manner as the By-Laws may prescribe.

ARTICLE J

MANNER OF ADOPTION AND VOTE

Section J.1. Action by Directors On February 1, 1996, a resolution was adopted by the Board of Directors of the Corporation proposing to the Shareholder of the Corporation entitled to vote in respect of the Amendment that the provisions and terms of its Articles of Incorporation be amended so as to read as set forth in these Articles of Incorporation and Redomestication and meeting of such Shareholder was called to be held February 1, 1996 to adopt or reject the Articles of Incorporation and Redomestication, unless the same was so approved by written consent.

Section J.2. Action by Shareholder At a duly-called meeting held February 1, 1996 the holder of one million two hundred sixty thousand shares of the Corporation, being all of the shares of the Corporation entitled to vote in respect of the Amendment, adopted the Amendment.

Section J.3. Compliance with Legal Requirements The manner of the adoption of the Amendment, and the vote by which it was adopted, constitute full legal compliance with the

Indiana Secretary of State
Packet: 1996031230
Filing Date: 03/21/1996
Effective Date: 03/21/1996

provisions of the Indiana Insurance Law, the Articles of Incorporation and the By-Laws of the Corporation.

ARTICLE K

Meetings of stockholders may be held within or without the State of Indiana, as the by-laws may provide. The books of the Corporation may be kept outside the state of Indiana at such place or places as may be designated from time to time by the Board of Directors or in the by-laws of the Corporation.

ARTICLE L

The Corporation reserves the right to amend, alter, change or repeal any provision contained in these Articles of Incorporation in the manner now or hereinafter prescribed herein and by the laws of the State of Indiana, and all rights conferred upon stockholders herein are granted subject to this reservation.

James A. White

Jeremiah J. Hanrahan

Wayne R. Hanus

Subscribed and sworn to before me this 19th day of February, 1996.

KIM R. NOVAK
Notary Public of New Jersey
My Commission Expires May 17, 2000
Lic. 2177955

Notary Public

(osbylaw)Kim

STATE OF INDIANA

OFFICE OF THE ATTORNEY GENERAL

INDIANA GOVERNMENT CENTER SOUTH, FIFTH FLOOR
402 WEST WASHINGTON STREET - INDIANAPOLIS, IN 46204-2770

PAMELA CARTER
ATTORNEY GENERAL

TELEPHONE (317) 233-6201

March 21, 1996

CERTIFICATION

I have examined the Articles of Incorporation and Redomestication of Anthem Health and Life Insurance Company and I certify that they conform to the provisions of the Indiana Insurance Law and are not inconsistent with the State and Federal Constitutions.

Respectfully submitted,

PAMELA CARTER
Attorney General of Indiana
Atty No. 0004242-49

Gordon E. White, Jr.
Deputy Attorney General
Atty No. 0001041-49

84019

The Indiana Secretary of State filing office certifies that this copy is on file in this office.

Indiana Secretary of State
Packet: 1996031230
Filing Date: 03/10/1999
Effective Date: 03/10/1999

1996031230

FILING #0004114403 PG 14 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02820
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

CERTIFICATE - CHANGE IN PRINCIPAL OFFICE

To: Indiana Department of Insurance
311 W. Washington Street, Suite 300
Indianapolis, IN 46204

To: Indiana Secretary of State
201 State House
Indianapolis, IN 46204

This will certify that, pursuant to authorization by the Board of Directors, the Principal Office of Anthem Health & Life Insurance Company has changed to 10401 North Meridian Street, Suite 350, Indianapolis, Indiana 46290.

G.R. Derback, Vice President and Treasurer

R.G. Schultz, Assistant Secretary

STATE OF Colorado)
) ss.
COUNTY OF Arapahoe)

On this 1st day of March, 1999, the undersigned personally appeared before me, known to me to be the persons whose names are subscribed above as Glen R Derback and Richard G. Schultz, and acknowledged that they have executed the same, and that the foregoing statements are true and correct.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal.

Notary Public

VALERIE A. ADAIR NOTARY PUBLIC STATE OF COLORADO

My Commission Expires: April 9, 2000

Certification Number: 2010011365565

The Indiana Secretary of State filing office certifies that this copy is on file in this office.

19960 31230

NOTICE OF CHANGE OF REGISTERED OFFICE OR REGISTERED AGENT ALL CORPORATIONS

State Form 26276 (R / 1-88)

Provided by: EVAN BAYH
Indiana Secretary of State
Room 155, State House
Indianapolis, IN 46204
(317) 232-6576

Indiana Code 23-1-24-2 (for profit corporations)
Indiana Code 23-7-1.1-53 (non-profit corporations)
NO FILING FEE

President: original and 2 copies

Name of Corporation	Date of Incorporation
Anthem Health Life Insurance Company	March 21, 1996

Current Registered Office Address	ZIP Code
120 Monument Circle, Indianapolis, IN	46204

New Registered Office Address
One North Capitol Avenue, Indianapolis, Indiana 46204

Current Registered Agent *(Type or Print Name)*
Sandra Miller

New Registered Agent *(Type or Print Name)*
C T Corporation System

STATEMENT BY REGISTERED AGENT OR CORPORATION

This statement is a representation that the new registered agent has consented to the appointment as registered agent, or statement attached signed by registered agent giving consent to act as the new registered agent.

After the change or changes are made, the street address of this corporation's registered agent and the address of its registered office will be identical.

The resident agent filing this statement of change of the registered agent's business street address has notified the represented corporation in writing of the change, and the notification was manually signed or signed in facsimile.

IN WITNESS WHEREOF, the undersigned being the Assistant Secretary of said corporation executes this notice and verifies, subject to penalties of perjury, that the statements contained herein are true, this 7 day of April, 19 99

Signature	Printed Name
R. Schultz	Richard Schultz

(INDIANA - 847 - 3/3/88)

The Indiana Secretary of State filing office certifies that this copy is on file in this office.

19960312 30

FILING #0004114403 PG 16 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02822
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

STATEMENT OF CONSENT TO ACT
AS REGISTERED AGENT

C T Corporation System hereby accepts the appointment to serve as registered agent in Indiana for Anthem Health & Life Insurance Company
(Name of Corporation)

4-13, 1999

C T CORPORATION SYSTEM

By Marcia J. Sunahara

Marcia J. Sunahara, Asst. V.P.
(Print Name and Title)

(IND. - 855 - 6/21/88)

APPROVED
AND
FILED
IND. SECRETARY OF STATE

APPROVED
DEPARTMENT OF INSURANCE
JUN 30 1999
STATE OF INDIANA
INSURANCE COMMISSIONER

RECEIVED
CORPORATIONS DIV.
99 JUL 19 PM 3:55
SUE ANNE GILROY

RECEIVED
JUL 02 1999
ATTORNEY
OF INDIANA

RESTATED ARTICLES OF INCORPORATION
OF
ALTA HEALTH & LIFE INSURANCE COMPANY

PREAMBLE

The Corporation was originally incorporated on May 2, 1963 under the laws of the State of Florida as Orange State Life Insurance Company. On June 15, 1982, the Corporation's name was changed to Home Life Financial Assurance Corporation. On August 1, 1994, the Corporation transferred its corporate domicile from the State of Florida to the State of Ohio. On March 21, 1996, the Corporation's name was changed to Anthem Health & Life Insurance Company and its corporate domicile was transferred from the State of Ohio to the State of Indiana.

These Restated Articles of Incorporation supersede the existing Articles of Incorporation and Redomestication of Anthem Health & Life Insurance Company.

ARTICLE A

NAME OF THE CORPORATION

The name of the Corporation is ALTA HEALTH & LIFE INSURANCE COMPANY.

ARTICLE B

PRINCIPAL OFFICE

The address of the Corporation's principal office in the State of Indiana is 10401 North Meridian Street, Suite 350, Indianapolis, Indiana 46290.

ARTICLE C

PURPOSES

The Corporation is organized under the Indiana Insurance Law, Chapter 162 of the Acts of 1935, as amended, and the purposes for which it is organized are:

> To insure the lives of persons and to make every insurance appertaining thereto or connected therewith including insurance against permanent mental or physical disability resulting from accident or disease, or against accidental death combined with a policy for life insurance and to grant, purchase or dispose of annuities.

FILING #0004114403 PG 18 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02824
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

To insure against bodily injury or death by accident and against disablement resulting from sickness and every insurance appertaining thereto.

All to the extent permitted and authorized by the Department of Insurance.

ARTICLE D

TERM OF EXISTENCE

The term for which the Corporation shall continue is perpetual.

ARTICLE E

SHARES

The total number of shares which the Corporation has authority to issue is 2,000,000 shares of common stock with a par value of $2.00 each, for total authorized capital of $4,000,000.

ARTICLE F

PAID-IN CAPITAL

The amount of paid-in capital is $2,520,000.

ARTICLE G

PLAN OF BUSINESS

The business of the Corporation shall be conducted on the legal reserve stock plan.

ARTICLE H

DIRECTORS AND OFFICERS

The following are the names and addresses of the directors of the Corporation who have been elected to serve until the next annual meeting of shareholders, or until their successors are elected and qualified:

Director's Name	Address
Mitchell T.G. Graye	8515 E. Orchard Road Englewood, Colorado 80111
William T. McCallum	8515 E. Orchard Road Englewood, Colorado 80111

Certification Number: 2010011365565

FILING #0004114403 PG 19 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02825
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

Director's Name	Address
Steve H. Miller	8505 E. Orchard Road Englewood, Colorado 80111
James D. Motz	8505 E. Orchard Road Englewood, Colorado 80111
Michael R. Quigley	10401 N. Meridian Street, Suite 350 Indianapolis, Indiana 46290
Martin Rosenbaum	8505 E. Orchard Road Englewood, Colorado 80111
James A. White	1 Centennial Avenue Piscataway, New Jersey 08854

The following are the names, positions and addresses of the principal officers of the Corporation who have been elected to serve until the next annual meeting of directors, or until their successors are elected and qualified:

Officer's Name	Position Held	Address
William T. McCallum	Chairman of the Board	8515 E. Orchard Road Englewood, Colorado 80111
James D. Motz	Vice Chairman and Chief Executive Officer	8505 E. Orchard Road Englewood, Colorado 80111
James A. White	President	1 Centennial Avenue Piscataway, New Jersey 08854
Mitchell T.G. Graye	Executive Vice President and Chief Financial Officer	8515 E. Orchard Road Englewood, Colorado 80111
John T. Hughes	Senior Vice President and Chief Investment Officer	8515 E. Orchard Road, Englewood, Colorado 80111
D.Craig Lennox	Senior Vice President, General Counsel and Secretary	8515 E. Orchard Road, Englewood, Colorado 80111
Glen R. Derback	Vice President and Treasurer	8515 E. Orchard Road, Englewood, Colorado 80111
James L. McCallen	Vice President and Actuary	8515 E. Orchard Road, Englewood, Colorado 80111

FILING #0004114403 PG 20 OF 30 VOL B-013
FILED 03/05/2010 12:30 PM PAGE 0282
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

ARTICLE I

PROVISIONS FOR REGULATION OF BUSINESS AND CONDUCT OF AFFAIRS OF CORPORATION

Section I.1. The Corporation shall have the right to engage in all lines of activity allied with or incidental to the purposes for which it is formed, not forbidden by the laws of the State of Indiana, and shall have the capacity to act, the authority and all of the general rights, privileges and powers referred to in Section 80 of Chapter 162 of the Acts of 1935, as amended.

Section I.2. The number of Directors of the Corporation shall not be less than five nor more than twenty-one, the exact number of Directors to be determined, from time to time, in such manner as the By-Laws may prescribe.

ARTICLE J

MANNER OF ADOPTION AND VOTE

Section J.1. Action by Directors. On June 15, 1999, a resolution was adopted by the Board of Directors of the Corporation proposing to the sole shareholder of the Corporation that the provisions and terms of its Articles of Incorporation and Redomestication be amended so as to read as set forth in these Restated Articles of Incorporation.

Section J.2. Action by Sole Shareholder. On June 15, 1999, a resolution was adopted by the sole shareholder of the Corporation, adopting these Restated Articles of Incorporation.

Section J.3. Compliance with Legal Requirements. The manner of the adoption of the Restated Articles of Incorporation, and the vote by which it was adopted, constitute full legal compliance with the provisions of the Indiana Insurance Law, the Articles of Incorporation and Redomestication and the By-Laws of the Corporation.

Certification Number: 2010011365565

ARTICLE K

The Corporation reserves the right to amend, alter, change or repeal any provision contained in these Restated Articles of Incorporation in the manner now or hereinafter prescribed herein and by the laws of the State of Indiana, and all rights conferred upon stockholders herein are granted subject to this reservation.

J.D. Motz
Vice Chairman and
Chief Executive Officer

D.C. Lennox
Senior Vice President,
General Counsel and Secretary

Subscribed and sworn before me this 25th day of June, 1999

Notary Public

My commission expires April 9, 2000.

APPROVED
AND
FILED
IND. SECRETARY OF STATE

STATE OF INDIANA
OFFICE OF THE ATTORNEY GENERAL

INDIANA GOVERNMENT CENTER SOUTH, FIFTH FLOOR
402 WEST WASHINGTON STREET • INDIANAPOLIS, IN 46204-2770

JEFFREY A. MODISETT
ATTORNEY GENERAL

TELEPHONE (317) 232-6201

19960812350

July 10, 1999

RECEIVED
99 JUL 19 PM 3:50
SUE ANNE GILROY

CERTIFICATION

I have examined the Restated Articles of Incorporation of Alta Health & Life Insurance Company which is changing its name from Anthem Health & Life Insurance Company, and I certify that they conform to the provisions of the Indiana Insurance Law and are not inconsistent with the State and Federal Constitutions.

Respectfully submitted,

JEFFREY A. MODISETT
Attorney General of Indiana
Atty No. 0014704-49

Gordon E. White, Jr.
Deputy Attorney General
Atty No. 0001041-49

15981

ALTA

1996031230

Alta Health & Life Insurance Company
P.O. Box [illegible]
Denver, CO [illegible]
[illegible]
[illegible]

February 8, 2001

Sue Anne Gilroy
Indiana Secretary of State
P.O. Box 5501
Indianapolis, IN 46255

RE: Alta Health & Life Insurance Company

Dear Mrs. Gilroy:

This letter is sent to inform you of a change in the presidency of Alta Health & Life Insurance Company. Effective January 1, 2001 James White retired from his position as President. J. D. Motz, the current Chairman and Chief Executive Officer was appointed to fill the presidency. His biographical affidavit is currently on file with your office because of his previous positions as Director and Officer of the corporation.

Also, please note that our corporate office has had a change in the city name, due to postal reorganization. The address is: 8505 East Orchard Road, Greenwood Village, CO 80111.

Thank you for adding this information to our business entity file.

Sincerely,

Connie Page

Connie Page
Legal Assistant

1996031230

Alta Health & Life Insurance Company
PO Box 230
Denver, CO 80201-0239
800-521-5124
www.altic.com

February 8, 2001

Sue Anne Gilroy
Indiana Secretary of State
P.O. Box 5501
Indianapolis, IN 46255

APPROVED
AND
FILED
IND. SECRETARY OF STATE

RE: Alta Health & Life Insurance Company

Dear Mrs. Gilroy,

This letter is sent to inform you of a change in the presidency of Alta Health & Life Insurance Company. Effective January 1, 2001 James White retired from his position as President. J. D. Motz, the current Chairman and Chief Executive Officer was appointed to fill the presidency. His biographical affidavit is currently on file with your office because of his previous positions as Director and Officer of the corporation.

Also, please note that our corporate office has had a change in the city name, due to postal reorganization. The address is: 8505 East Orchard Road, Greenwood Village, CO 80111.

Thank you for adding this information to our business entity file.

Sincerely,

Connie Page

Connie Page
Legal Assistant

INDIANA SECRETARY OF STATE

SYSTEM GENERATED
ADMINISTRATIVE DISSOLUTION/REVOCATION

Pursuant to the provisions set forth in Indiana Code Title 23
the entity has been Administratively Dissolved or
the Certificate of Authority revoked.

A certified copy of this document authenticates the date of
the Administrative Dissolution/Revocation

The Indiana Secretary of State filing office certifies that this copy is on file in this office.

Indiana Secretary of State
Packet: 1996031230
Filing Date: 05/21/2002
Effective Date: 05/21/2002

State of Indiana
Office of the Secretary of State

CERTIFICATE OF REINSTATEMENT

of

ALTA HEALTH & LIFE INSURANCE COMPANY

I, SUE ANNE GILROY, Secretary of State of Indiana, hereby certify that Application of Reinstatement of the above For-Profit Domestic Corporation have been presented to me at my office, accompanied by the fees prescribed by law and that the documentation presented conforms to law as prescribed by the provisions of the Indiana Business Corporation Law

NOW, THEREFORE, with this document I certify that said transaction will become effective Tuesday, May 21, 2002

In Witness Whereof, I have caused to be affixed my signature and the seal of the State of Indiana, at the City of Indianapolis, May 21, 2002.

Sue Anne Gilroy

SUE ANNE GILROY,
SECRETARY OF STATE

1996031230 / 20020524597O2

FILING #000411440 3 PG 26 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02832
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

The Indiana Secretary of State filing office certifies that this copy is on file in this office.

Indiana Secretary of State
Packet: 1996031230
Filing Date: 05/21/2002
Effective Date: 05/21/2002

19960312 30

APPLICATION FOR REINSTATEMENT

State Form 4160 (R6 / 3-97) / 111
Approved by the State Board of Accounts 1995

SUE ANNE GILROY
SECRETARY OF STATE
CORPORATIONS DIVISION
302 W Washington St., Rm. E018
Indianapolis, IN 46204
Telephone: (317) 232-6576

Indiana Code 23-1-46-3 *(for profit corporation)*
Indiana Code 23-17-23-3 *(not-for-profit corporation)*

Application must include:

1. Certificate of Clearance issued by the Indiana Department of Revenue
2. Corporate Reports and Fees: please call our information line to learn what reports are delinquent (317) 232-6576
   a. Up to and including 1995, Annual Reports filed every year.
      Annual Report fee $10.00
   b. Beginning with 1996, Biennial Reports filed every two years.
      Biennial Report fee $30.00
      Corporations incorporated in an even year, file every even year.
      Corporations incorporated in an odd year, file every odd year.
   c. Nonprofit corporations file Annual Reports every year.
      Nonprofit Corporate Report fee $10.00
3. Restatement filing fee: $30.00

APPROVED
INDIANA SECRETARY OF STATE

THIS APPLICATION CANNOT BE ACCEPTED WITHOUT A NOTICE OF CLEARANCE FOR REINSTATEMENT FROM THE INDIANA DEPARTMENT OF REVENUE.

SECTION I - CORPORATE INFORMATION

Name of corporation	Date of incorporation *(mo., day, yr.)*
Alta Health & Life Insurance Company	5/2/1963

Effective date of administrative dissolution
2/8/2002

SECTION II - AFFIDAVIT OF CORPORATE OFFICER OF DIRECTOR

The undersigned, being at least one of the principal officers or a director of the above-named corporation deposes and says:

A. that the grounds for dissolution did not exist or have been eliminated, and,

B. that the Corporation's name satisfies the requirements of Indiana Code 23-1-23-1, or Indiana Code 23-17-5-1.

IN WITNESS WHEREOF, the undersigned being the Assistant Secretary (Title) of said corporation executes this application and verifies, subject to penalties of perjury, that the statements contrained herein are true, this 1st day of May, 19 2002.

Signature	Printed name
R. Schultz	Richard G. Schultz, Assistant Secretary

Certification Number: 2010011365565

The Indiana Secretary of State filing office certifies that this copy is on file in this office.

Indiana Secretary of State
Packet: 1996031230
Filing Date: 05/21/2002
Effective Date: 05/21/2002

FILING #0004114403 PG 28 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02834
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

RECEIVED
APR 26 2002
LAW DEPT

AD-190 (Rev. 1/01)
SF#

Indiana Department of Revenue
CERTIFICATE OF CLEARANCE FOR REINSTATEMENT

Name of Corporation

Alta Health & Life Insurance Company
8515 East Orchard Road
Greenwood Village, CO 80111

Federal ID#
591031071
TID #
0102240450
Date Issued (Valid for 60 days)
04/12/2002

TO: Sue Anne Gilroy
Secretary of State
Corporations Division

The corporation named above has filed with the Department of State Revenue an affidavit, Form AD-19, disclosing that the corporation is applying for a Certificate of Reinstatement from the Secretary of State, and requesting a Certificate of Clearance from this Department stating all taxes and fees owed by the corporation have been paid.

An examination of the corporation's existing accounts for listed taxes and fees required to be administered or collected by the Department has determined that all taxes, fees, interest, and penalties due have been paid or satisfied. Execution of this document does not preclude the Department from future examination and adjustment of the corporation's Indiana tax accounts for any period.

This Certificate of Clearance shall be null and void sixty (60) days after its date of issue.

Kenneth L. Miller, Commissioner
Indiana Department of Revenue

Diane Freeman, Administrator
Compliance Division

BY:

Instructions to the corporation:

This notice is the signed original. You are to include this certification along with the other documents constituting your **Application for Reinstatement (SF#4160)**. Do Not Mail this certificate separately to the Secretary of State unless you are so directed.

Certification Number: 2010011365565

The Indiana Secretary of State filing office certifies that this copy is on file in this office

FILING #000411403 PG 29 OF 30 VOL B-01317
FILED 03/05/2010 12:30 PM PAGE 02835
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

NOTICE OF CHANGE OF PRINCIPAL OFFICE ADDRESS
State Form 50656 (R/1-03)

RECEIVED
CORPORATIONS DIV.
09 MAY 22 PM 1:15

TODD ROKITA
SECRETARY OF STATE
CORPORATIONS DIVISION
302 W. Washington St., Rm. E018
Indianapolis, IN 46204
Telephone: (317) 232-6576

INSTRUCTIONS: *Use 8 1/2" x 11" white paper for attachments.*
Present original and one copy to address in upper right corner of this form.
Please TYPE or PRINT.
Please visit our office on the web at www.sos.in.gov

Indiana Code 23-1-1-1 et seq.

NO FILING FEE

Name of corporation or other entity	Date of incorporation / organization / reclamation
Alta Health & Life Insurance Co.	3/21/1996
Current principal office address (number and street, city, state, ZIP code)	
8515 E. Orchard Road, Greenwood Village, CO 80111	
New principal office address (number and street, city, state, ZIP code)	
11595 N. Meridian Street, Suite 600, Carmel, IN 46032	

IN WITNESS WHEREOF, the undersigned executes this notice and verifies, subject to the penalties of perjury, that the statements contained herein are true, this 19th day of May 20 09

Signature	Title
Jennifer Grant	Assistant Secretary

Indiana Secretary of State
Packet: 1996031230
Filing Date: 05/22/2009
Effective Date: 05/22/2009

APPROVED AND FILED
IND. SECRETARY OF STATE

COPY

Certification Number: 2010011365565

CIGNA CORPORATION
1601 Chestnut Street
Philadelphia, PA 19192

March 5, 2010

FILING #0004114403 PG 30 OF 30 VOL B-01379
FILED 03/05/2010 12:30 PM PAGE 02836
SECRETARY OF THE STATE
CONNECTICUT SECRETARY OF THE STATE

Connecticut Secretary of State
30 Trinity Street
Hartford, CT 06106

Re: CIGNA Health and Life Insurance Company

Dear Sir/Madam:

I currently have the above-referenced name reserved for use in Connecticut. I hereby transfer the reservation to CT Corporation System.

Thank you for your assistance.

Very truly yours,

Jennifer A. Shank