Equifax Inc.

Medical Plan

Summary Plan Description

EQUIFAX

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Medical Plan

A Quick Look at Your Medical Plan

To support the healthcare needs of you and your family, Equifax offers four Medical Plan options. Coverage is available for you and any eligible dependents. You also have the option to decline medical coverage.

Eligibility

You are eligible for coverage under the Medical Plan if you are classified as an Eligible Employee by the Company. See the Overview Section for additional details regarding eligibility.

You may elect coverage as a new hire, during the Annual Enrollment Period or during the year if you have a Qualifying Family Status Event. You may also elect coverage for your eligible dependents as described in the Overview section. Details on when your coverage takes effect can also be found in the Overview section located on People Link.

If you become eligible for Short-Term Disability benefits, medical coverage continues under the Medical Plan as set forth in this Summary Plan Description. Please see the "Special Situations" Section later in this SPD regarding your medical coverage while disabled.

Eligibility for Retiree Medical Coverage

If you are eligible for medical coverage following retirement from Equifax (either pre-65 or post-65 coverage), your coverage will be provided by the Equifax Inc. Retiree Health Care Program. Eligibility and coverage is discussed in either the Pre-65 Retiree Medical Summary Plan Description or the Post-65 Retiree Medical Summary Plan Description.

Special Eligibility Rules

The following special rules apply to your medical coverage, as noted below within each special rule:

- Certain exceptions to the eligibility rules apply to corporate acquisitions and employees assigned to non-U.S. locations. You will be notified if these apply to you.

- A family member cannot be enrolled as both your dependent and the dependent of another Equifax employee or retiree.

- If you and your spouse or domestic partner are both Equifax employees, you may each enroll as separate employees, or either of you may enroll as an employee and the other as a spouse or domestic partner.

Coverage for Active Employees Eligible for Medicare

If you become eligible for Medicare while employed by the Company, you will continue to be covered under your medical plan option, and benefits will integrate with those payable from Medicare. Generally, you are eligible for Medicare upon reaching age 65, or due to permanent kidney failure. In such event, your medical option will be primary—that is, you will receive benefits from the Equifax medical plan option first. However, your medical option will only be primary due to permanent kidney failure for the time periods specified in federal law. Then you can submit your expenses for reimbursement under Medicare (if you are enrolled). The benefits you receive from the Equifax medical option and from Medicare cannot be greater than your total expenses. You should contact your local Social Security office for information about Medicare as soon as you are eligible.

While you are an active employee, your eligible dependents who are Medicare-eligible (whether due to reaching age 65 or being disabled) will have primary coverage under your Equifax medical plan option, and secondary coverage under Medicare. Once you no longer are an active employee, Medicare coverage will become primary for you and your eligible dependents who are Medicare-eligible. This includes the period of time you are on COBRA continuation coverage. If you or your dependent are Medicare-eligible and are on COBRA continuation coverage, Medicare will become primary, and you should enroll in Medicare Part B as soon as you are eligible, as a penalty applies for late enrollments in Medicare Part B. If you enroll late, Medicare can apply this penalty for as long as you are enrolled in Part B.

Coverage for Active Employees Eligible for Medicare Part D

Your coverage under the Equifax Medical Plan covering you as an active employee, or dependent or Spouse of an active employee will not be affected, if you or your Medicare-eligible dependent or spouse enrolls in a Medicare prescription drug plan. However, if you drop coverage with Equifax and enroll in a Medicare prescription drug plan, you will not be able to re-enroll for active coverage in the Equifax Medical Plan until the next annual enrollment period, or a qualifying change in status, if earlier (provided that you are otherwise still eligible at the time you propose to enroll). In addition, your current Equifax coverage pays for medical expenses, in addition to prescription drugs, and if you choose to drop prescription drug coverage from Equifax you must also drop your medical coverage as well. Therefore, you should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

You should also know if you drop or lose your Equifax coverage and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. In addition, the $4,000 Deductible medical option is not creditable coverage for Medicare Part D purposes. Therefore, if you are an active employee and you or your spouse are Medicare eligible or will be during the applicable calendar year, you should not enroll in the $4,000 Deductible medical option. If

you do enroll in the $4,000 Deductible medical option and you or your spouse are Medicare eligible, you may pay more to enroll in Medicare prescription drug coverage after you are no longer enrolled in an Equifax medical option.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage; your Medicare monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other participants pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Medicare.

Certain other rules may apply. See the Medicare Part D Notice for more information.

☑ To Your Benefit

When selecting your medical plan and deciding who to cover, consider this:

- Under the Plan's **Coordination of Benefits** rules, benefits under the Equifax Medical Plan may be reduced by those available from other plans. Think about whether you (or your dependents) need multiple coverage sources (i.e., spousal plan, prior employer plan, etc.). It actually may be *less* expensive to have only one source of benefits.

- If you are enrolled in the $1,000 Deductible medical option, you may use a Health Flexible Spending Account and be reimbursed with before-tax dollars deducted from your biweekly pay for your out-of-pocket deductible, copay, coinsurance cost and many uncovered services. If you are enrolled in the $2,000, $3,000 or $4,000 Deductible medical options, you may enroll in the Limited-Purpose Flexible Spending Account. The limited-purpose account allows you to be reimbursed tax-free for uncovered dental and vision expenses prior to meeting your medical option annual deductible. Once your medical option annual deductible has been satisfied, you may be reimbursed for uncovered medical, dental and vision expenses.
- If you or your spouse are Medicare eligible or will be during the applicable calendar year, you should note that the $4,000 Deductible medical option is not considered creditable coverage under Medicare Part D. Therefore, you should enroll in another medical option – otherwise your Medicare Part D premiums will be higher when you do enroll in Medicare Part D later. See the Medicare Part D Notice in People Link under the Health and Benefits section.

Cost

While you remain an employee, your cost is determined by the medical option you choose and the dependents you elect to cover. Unless otherwise prohibited by local law, you pay your

share of the cost for coverage with pre-tax dollars that are deducted from your biweekly paycheck.

Spousal / Partner Surcharge

Access to Equifax medical plans will continue to be provided to eligible spouses and domestic partners. However, an additional charge will apply if your enrolled spouse or partner has access to group major medical coverage through his/her own employer.

An additional biweekly charge of $70 will be deducted from the employee's paycheck if his/her covered spouse or domestic partner has access to group major medical coverage through his/her own employer. The surcharge does not apply to couples (spouses and domestic partners) that are both employed by Equifax.

Tobacco Surcharge

To promote good health, an additional biweekly charge of $50 will apply if you use tobacco. During annual enrollment each year you will be asked to certify your use of tobacco products.

If you use tobacco and also complete a tobacco cessation program, the $50 surcharge will not apply to you. Contact CIGNA at 800-244-6224 for information and to enroll in the tobacco cessation program.

Surcharge Conditions

The application of the additional spouse / partner surcharge and the tobacco surcharge is always and completely subject to audit. Equifax may apply the additional surcharge(s) retroactively, if Equifax determines that the surcharge applies (in an audit or otherwise). Surcharges collected prior to an enrollment change or change in enrollment status will not be refunded. Surcharges are in addition to your regular medical premiums.

Healthy Babies Program

You can earn a reward of $75 or $150 for participating in the Healthy Babies Program. If you are pregnant, contact CIGNA for additional information on how to enroll.

Health Matters

Use *Health Matters*, a new interactive health assessment tool, for personalized support to help you and your covered dependents age 18 and older meet your wellness goals. This tool is available on www.myCigna.com.

Medical Plan Considerations

The Medical Plan options offered to you generally cover the same expenses but differ in monthly cost, how you access care and how your out-of-pocket expenses are managed.

> ☑ **To Your Benefit**
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> Equifax strongly encourages you to consider having comprehensive medical coverage through one of these options or a plan available through other sources such as a spouse. Remember, even if you're young and healthy, the medical expenses resulting from an accident or unexpected illness could be financially devastating.

Medical Plan Options

Overview of Options

Equifax offers three different medical plan options, each with its own special rules and considerations.

Medical Plan Options	Special Rules
$1,000 Deductible Plan	You have the option to see any physician within or outside the network. However, you must use in-network providers for preventive care services. Out-of-network claims are subject to the maximum reimbursable charge. A primary care provider is not required and referrals are not necessary to see in-network specialists. You may enroll in the health care flexible spending account (HCFSA). In-network medical and dental expenses are paid automatically from your account through auto-claim forwarding.

Medical Plan Options	Special Rules
$2,000 Deducible, $3,000 Deductible, and $4,000 Deductible	You have the option to see any physician within or outside the network. However, you must use in-network providers for preventive care services. Out-of-network claims are subject to the maximum reimbursable charge. A primary care provider is not required and referrals are not necessary to see in-network specialists. These plans are Consumer Driven Health Plans. By enrolling in one of these plans, you are also eligible to start and contribute to a health savings account (HSA) with Fidelity. You may also enroll in the Limited-Purpose Flexible Spending Account (LPFSA). Before you meet your medical option deductible, you can use this account to pay for eligible vision and dental expenses.

Comparison of Medical Plan Options

Benefit	$1,000 Deductible		$2,000 Deductible[1]		$3,000 Deductible[1]		$4,000 Deductible[1]	
	IN	OUT[2]	IN	OUT[2]	IN	OUT[2]	IN	OUT[2]
Annual Deductible								
Individual	$1,000	$2,000	$2,000	$4,000	$3,000	$6,000	$4,000	$8,000
Individual in Family	$1,000	N/A	N/A	N/A	N/A	N/A	$6,850	$16,000
Family	$3,000	$6,000	$4,000	$8,000	$6,000	$12,000	$8,000	$16,000
Annual Out-of-Pocket Maximum								
Individual	$3,000	$6,000	$2,500	$5,000	$3,500	$7,000	$6,750	$13,500
Individual in Family[3]	$3,000	N/A	$5,000	N/A	$6,850	$14,000	$6,850	$27,000
Family	$9,000	$18,000	$5,000	$10,000	$7,000	$14,000	$13,500	$27,000
Lifetime Maximum	No lifetime maximum on essential health benefits.							
Office Visit Primary Care Physician	You pay 20% (no deducti-ble)	You pay 40%	You pay 10%	You pay 30%	You pay 20%	You pay 40%	You pay 30%	You pay 50%
Office Visit Specialty Care Physician	You pay 20%	You pay 40%	You pay 10%	You pay 30%	You pay 20%	You pay 40%	You pay 30%	You pay 50%

[1] If you are enrolled in family coverage, see the section after this chart for additional information on the deductible.
[2] Subject to maximum reimbursable charge.
[3] If you are enrolled in family coverage, see the section after this chart for additional information on the out of pocket maximum.

Benefit	$1,000 Deductible		$2,000 Deductible[1]		$3,000 Deductible[1]		$4,000 Deductible[1]	
	IN	OUT[2]	IN	OUT[2]	IN	OUT[2]	IN	OUT[2]
Preventive Care[4]	You pay $0	No coverage	You pay $0	No coverage	You pay $0	No coverage	You pay $0	No coverage
Emergency Care	You pay 20%		You pay 10%		You pay 20%		You pay 30%	
Urgent Care	$50 copay (no deductible)		You pay 10%		You pay 20%		You pay 30%	
Inpatient and Out-patient Hospital Services[5]	You pay 20%	You pay 40%	You pay 10%	You pay 30%	You pay 20%	You pay 40%	You pay 30%	You pay 50%
Diagnostic X-ray and Laboratory[6]	You pay 20%	You pay 40%	You pay 10%	You pay 30%	You pay 20%	You pay 40%	You pay 30%	You pay 50%
Chiropractic Services[7]	You pay 20%	You pay 40%	You pay 10%	You pay 30%	You pay 20%	You pay 40%	You pay 30%	You pay 50%
Most Other Medically Necessary Services[8]	You pay 20%	You pay 40%	You pay 10%	You pay 30%	You pay 20%	You pay 40%	You pay 30%	You pay 50%

[4] Limited to certain preventive care expenses, see Covered Medical Benefits Section for further information. Deductible does not apply to preventive care.
[5] Inpatient hospitalization requires precertification.
[6] Lab tests that are treated as preventive care are paid as preventive care, see Covered Medical Benefits.
[7] Benefits limited to 20 visits per person, per year.
[8] Limitations apply to certain services as follows –

- Some services require pre-authorization, contact Cigna for additional information.
- Home health care, skilled nursing, rehabilitation hospital, and sub-acute facility limited to 120 visits per person, per year.
- Physical, Speech and Occupational Therapy limited to 60 days per person, per year.
- Private duty or special duty nursing is limited to 70 days per person, per year.
- Outpatient rehabilitation limited as follows – (1) pulmonary rehabilitation, cognitive therapy, physical therapy, speech therapy, occupational therapy and cardiac rehabilitation limited to 60 days per year, (2) chiropractic care limited to 20 days per year.
- See the Cigna Healthcare Benefit Summary for your medical plan option (posted on People Link) for additional information and limitations.

Benefit	$1,000 Deductible		$2,000 Deductible[1]		$3,000 Deductible[1]		$4,000 Deductible[1]	
	IN	OUT[2]	IN	OUT[2]	IN	OUT[2]	IN	OUT[2]
MDLIVE Telemedicine Visits	You pay 20% (no deductible)		You pay 10%		You pay 20%		You pay 30%	
Prescription Drug Section								
Prescription Drugs – Special Rules	No deductible applies to prescription drugs. The medical out of pocket maximum applies to prescription drugs. You must obtain your prescription drugs from a Cigna network pharmacy. There is no coverage for out of network pharmacies.		The medical deductible applies to prescription drugs. The medical out of pocket maximum applies to prescription drugs. You must obtain your prescription drugs from a Cigna network pharmacy. There is no coverage for out of network pharmacies.					
Prescription Drugs –Retail Charges apply for up to a 30-day supply.	You pay 20%	Not covered	Generic Preventive: No Charge All Other Prescription Drugs: You pay 10%	Not covered	Generic Preventive: No Charge All Other Prescription Drugs: You pay 20%	Not covered	Generic Preventive: No Charge All Other Prescription Drugs: You pay 30%	Not covered
Prescription Drugs – Mail Order Charges apply for up to a 90-day supply.	You pay 20%	Not covered	Generic Preventive: No Charge All Other Prescription Drugs: You pay 10%	Not covered	Generic Preventive: No Charge All Other Prescription Drugs: You pay 20%	Not covered	Generic Preventive: No Charge All Other Prescription Drugs: You pay 30%	Not covered

NOTE: All percentage coinsurance applies after the applicable deductible has been satisfied, unless otherwise noted in the chart above.

Puerto Rico Indemnity Plan

Eligibility: Only employees and their eligible dependents who live in Puerto Rico are eligible for the Puerto Rico Indemnity Plan.

Plan Features	Benefit
Lifetime Maximum	Unlimited for Essential Health Benefits
Out–Of–Pocket Maximum	
Individual	$100
Family Limit	$200
Primary Care Physician Visits	
Office hours	90%
After-hours/home	90%
Specialty Care	
Office visits	90%
Diagnostic OP lab/X-ray testing (at facility)	75%
Outpatient therapy (speech, physical, occupational)	90%; Limited to 60 visits per calendar year
Chiropractor Services	90%; Limited to 20 visits per calendar year
Outpatient dialysis/chemotherapy	100%
Allergy testing/treatment	90%
Preventive Care	
Routine Preventive Care and Immunizations for children and adults based on the AMA guidelines.	100%
Routine Eye Exam	Not covered
Vision Corrective Lenses/Contacts	Not covered
Hearing exam	Not covered
Hearing aids	Not covered
Urgent / Emergency Care	
Emergency Room	$50 per visit copay. No coverage for non-emergency use of emergency room
Urgent Care	100% No coverage for non-urgent care rendered by urgent care provider.
Ambulance	100%
Outpatient Surgery	100% for facility; 90% for services
Hospitalization*	100%; after $75 per admission copay
Maternity	
OB visits	100%
Hospital (includes newborn services)	100%; after $75 per admission copay
Home Health Care	100%; limited to 120 days per calendar year and 16 hour maximum per day.

Plan Features	Benefit
Private Duty or Special Duty Nursing	100%; limited to 70 days per calendar year and 8 hour maximum per day.
Family Planning/Reproductive Services	90%; diagnosis and treatment of underlying medical condition.
Sterilization procedures	Reversal of voluntary sterilization including related follow-up care and treatment of complications of such procedures is not covered.
Durable Medical Equipment	100%
Mental Health & Substance Abuse	
Inpatient	100%
Outpatient	90%
Most other medically necessary services	90%
Prescription Drugs	
Retail Pharmacy (up to 30 day supply; no coverage for out of network pharmacy)	$5 generic copay; $15 brand copay
Mail-Order Pharmacy (up to 90 day supply; no coverage for out of network pharmacy)	$10 generic copay; $30 brand copay
Diabetic Supplies	Rx copay
Contraceptives	Rx copay

Notes:

- All expenses are subject to the maximum reimbursable charge.
- Some services require precertification. Contact Cigna for additional information.
- See the Cigna Healthcare Benefit Summary (posted on People Link) for additional information and limitations.

Comparison of Accounts Relating to Medical Options

	HSA	Limited Purpose Health Care FSA (LP FSA)	Health Care (HC FSA)
Coordinates with Medical Option	$2,000 Deductible $3,000 Deductible $4,000 Deductible	$2,000 Deductible $3,000 Deductible $4,000 Deductible	$1,000 Deductible
Equifax Automatic contribution	None	None	None
Pre-tax contribution limits	$3,850 single $7,750 family*	$3,050 per employee	
Eligible Expenses	Medical, Prescription Drug, Dental and Vision	Dental and vision only***	Medical, prescription drug, dental and vision
It's yours to keep if you leave Equifax	Yes	No**	No**
Debit card	Yes	No	No
Earns interest	Yes	No	No
Rolls over year to year	Yes	No	No

Notes:
* Additional contribution of up to $1,000 is available if you are age 55 by the end of the year.
** Employees under certain COBRA situations can elect COBRA and continue to access account funds.
*** Medical and prescription drug out of pocket expenses can be reimbursed once you satisfy the medical deductible.

Health Savings Accounts

With the $2,000, $3,000 and $4,000 Deductible medical options, you can start and contribute to a health savings account (HSA) that allows you to save pre-tax money for eligible health care expenses. An HSA is a savings account for health expenses incurred today or in the future. Balances roll over from year to year, and the money is always yours to keep, even if you leave the Company. Because HSAs offer tax advantages, they're governed by federal regulations and have some special rules.

How to Open an HSA

You establish an HSA automatically with Fidelity when you complete your enrollment and agree to the terms and conditions established. You must complete any additional information requested by Fidelity to open your HSA account before any contributions can be made. Further, you will not be able to use your HSA for medical, dental and vision expenses incurred prior to the date that you open the HSA.

Employee Contributions

All HSA contributions are deducted pre-tax for federal and state income taxes from each paycheck (unless otherwise prohibited by state law). You can contribute any amount you like, up to the IRS allowable annual maximum for the calendar year. (If you cover any eligible individual, in addition to yourself—for example, a spouse, domestic partner or eligible child—the family coverage maximum will apply.) You may change the amount of your HSA contribution at any time by making such changes through Workday.

You are responsible for verifying that you do not go over the annual HSA contribution maximums. Any excess over the maximum is taxable to you and is subject to an annual excise tax on your federal income tax return.

In addition, catch-up contributions of up to $1,000 per year may be made if you are age 55 or older by the end of the applicable calendar year. If you have any questions regarding the amount or types of HSA contributions you can make, you should contact your personal tax advisor.

Qualified Health Care Expenses

You can reimburse yourself tax-free from your HSA for any qualified health care expenses. These expenses include most medically-necessary medical, dental and vision expenses that are not otherwise paid or reimbursed by Equifax health coverage or other insurance coverage you may have. In addition, qualifying expenses include COBRA premiums, long-term care insurance premiums, and Medicare premiums (but not a Medicare supplement policy). If you have expenses early in the year, you may not have enough funds built up in your HSA to pay the expense at that time with tax-free dollars. You can reimburse yourself with tax-free dollars later, as you contribute to your account. Fidelity also has a debit card option that is linked to your HSA account, thereby allowing you to pay for qualifying expenses at the time of service.

Keep in mind, the HSA has different rules for your dependents under the Internal Revenue Code (IRC) than the Equifax medical options. For the Equifax medical plans, you may enroll your dependent children up to age 26 on a tax-free basis. However, for the HSA, your child must be under age 19 or under age 24 for full-time students to use dollars in your HSA for his/her medical, dental and vision expenses. Tax-free reimbursements from your

HSA are also possible if your child is over age 19 (or over age 24 for students), if the IRS financial dependency rules are satisfied. For purposes of domestic partners, you may be reimbursed from your HSA for expenses incurred by your domestic partner (and his/her children) only if he/she satisfies the IRS requirements to be your Federal tax dependent. Contact your personal tax advisor for additional information.

Who Can Open an HSA

To open an HSA you must be enrolled in a High Deductible Health Plan, as defined under IRS rules. The $2,000, $3,000 and $4,000 Deductible medical options satisfy the IRS rules to open an HSA.

You may not contribute to an HSA if:

- You are covered under any other major medical plan, including a spouse's plan that is not a high deductible health plan (HDHP). However, separate dental and vision coverage, as well as certain other limited medical coverage (such as CIGNA Supplemental Insurance) is permitted.
- Your spouse or domestic partner is enrolled in a health flexible spending account that allows reimbursement of a broad range of health expenses.
- You are enrolled in Medicare.

Spouse / Partner Double Coverage – Special Issues

If you and your spouse / partner are enrolled in an HSA-eligible medical option, at the same time your spouse / partner also may be enrolled in other major medical plan coverage. Any time your spouse / partner is covered by two plans, the coordination of benefits rules will apply. (See, the "Double Coverage" section later in this SPD for additional details). In addition, special HSA rules also apply as follows:

- *You and your spouse / partner are enrolled in an HSA-eligible medical option, while only your spouse / partner is enrolled in Medicare.* In this situation, you can contribute the maximum HSA family contribution. However, your spouse / partner's claims will be coordinated between the Equifax medical option and Medicare. For your spouse / partner's claims, you can only obtain tax-free reimbursement from the HSA for the portion of the claims that are not paid by either the Equifax medical option or Medicare.

- *You and your spouse / partner are enrolled in an HSA-eligible option, while only your spouse / partner is enrolled in non-HDHP medical coverage through your spouse / partner's employer.* In this situation, you can contribute the maximum HSA family contribution. However, your spouse / partner's claims will be coordinated between the Equifax medical option and your spouse / partner's employer plan. For your spouse / partner's claims, you can only obtain tax-free reimbursement from the HSA for the portion of the claims that are not paid by either the Equifax medical option or the spouse / partner's employer plan.

- *You and your spouse / partner are enrolled in an HSA-eligible medical option, while only your spouse / partner is enrolled in HDHP medical coverage through your spouse / partner's employer.* In this situation, your spouse / partner is also eligible to contribute to an HSA in his / her name. For spouses, both you and your spouse are treated as having only HSA family coverage, combined. This means that the maximum HSA contribution must be divided between you and your spouse, and you are responsible for determining that you do not over contribute to your HSA. For domestic partners, different rules apply to HSA contributions and you should contact your tax advisor. For claims purposes, your spouse / partner's claims will be coordinated between the Equifax medical option and your spouse / partner's employer plan. You and your spouse can only obtain tax-free reimbursement from an HSA for the portion of the spouse's claims that are not paid by either the Equifax medical option or the spouse's employer plan.

Full Contribution Rule for Mid-Year Enrollees

If you enroll in an HSA-eligible Equifax medical option mid-year as either a new employee or due to a qualifying change in status, it is possible to contribute up to the full annual HSA contribution for the year. This is referred to as the "full contribution rule."

To take advantage of the "full contribution rule" for the first year, all of the following must be satisfied –

- You must enroll in one of the HSA-eligible Equifax medical options for coverage that is effective no later than December 1st of the year that you are taking advantage of the "full contribution rule," AND
- You must remain enrolled in an HSA-eligible Equifax medical option for the entire calendar year following the year in which you take advantage of the "full contribution rule".

If you only contribute to your HSA an amount pro-rated to the months in which you were actually enrolled in one of the HSA-eligible Equifax medical options, then the full contribution rule does not apply and you can switch to the $1,000 Deductible medical option for the following calendar year.

You are responsible for determining whether you have satisfied or will satisfy the full contribution rule requirements. Equifax is not responsible for this determination. If you have questions about how the full contribution rule works in your situation, you should contact your federal tax advisor.

Special Rules for the Flexible Savings Account

If you are enrolled or have elected to be enrolled in an HSA-eligible Equifax medical option for a calendar year, then you cannot enroll in or contribute to the Health Care FSA for the

same calendar year. However, you may still submit claims to a prior year's Health Care FSA (when you were not enrolled in an HSA-eligible medical option) for expenses incurred in the prior year up to March 31 of the following year.

If you incur a qualifying change in status during the year that allows a mid-year election change, special rules also apply. In that situation, during the mid-year change in status event you can switch your Equifax medical coverage and enroll in an HSA-eligible Equifax medical option for the remainder of the year. However, if you are also enrolled in the Health Care FSA at the time of the mid-year enrollment in an HSA-eligible Equifax medical option, your Health Care FSA contributions and enrollment will cease as of your change in status event. You will be able to obtain Health Care FSA reimbursement for expenses incurred prior to the change in status event based on contributions made up to that date, but not for expenses incurred after the change in status event.

Even though you cannot enroll in an HSA-eligible Equifax medical option and the Health Care FSA for the same calendar year, you may enroll in the Limited-Purpose Flexible Spending Account while you are also enrolled in an HSA-eligible Equifax medical option. Under the Limited-Purpose Flexible Spending Account you may be reimbursed for uncovered dental and vision expenses only prior to the date you satisfy the HSA-eligible Equifax medical option deductible for the year. After you satisfy the HSA-eligible Equifax medical option deductible, then you can be reimbursed for uncovered medical, prescription drug, dental and vision expenses incurred in the remainder of the year. See the Flexible Spending Account SPD section for additional information.

Using the Cigna Open Access Plus Network

If you live in a network area, every time you need care you have a choice of using in-network or out-of-network doctors and hospitals. When you receive medical care from an in-network doctor or hospital, your costs are lower and more services are covered. Annual routine physicals (including associated lab work) for you and your covered dependents, well-baby care, and certain tests and screenings are covered only when you use a network provider.

Cigna uses the Open Access Plus network. Cigna is responsible for selecting doctors, hospitals and other health care suppliers who participate in their networks. The screening process Cigna use's is extensive and most providers are regularly monitored and re-credentialed. Throughout the year, some providers may leave the networks they are part of. While the Company recognizes the disruption this causes employees, the Company is not able to reverse these decisions. If you continue to use these providers, your benefit will be paid at the out-of-network level.

You may find providers in the Cigna network by using the online provider search tool on www.cigna.com or www.mycigna.com.

ID Cards

Whenever you need care, you must use your ID card to identify yourself as a plan participant. If you do not have your ID card with you when you receive care, you may be required to submit payment to the doctor at the time of service. You will then need to send in a claim form for reimbursement. If you need additional ID cards, call Cigna or go to www.mycigna.com.

Providing your ID card to someone who is not enrolled in the plan may constitute fraud against the plan, for which your plan coverage may be terminated or suspended. You may also be required to repay claims that were paid as a result of the improper use of your ID card.

When You Visit the Doctor's Office

If you are seeing a network doctor, you will typically only pay your applicable copay or coinsurance at the time you receive care. Following care, the doctor will submit the bill to Cigna. You will then be billed for charges not paid by the plan. However, your doctor may request any remaining deductible and coinsurance at the time of services. The fee for service is generally lower with a network doctor.

If you visit a doctor who is not in the network, your costs will be higher. It's still a good idea to show your ID card so the receptionist can check your eligibility and coverage. In some cases, the out-of-network provider will file a claim for you. In other cases, you will have to file a claim for reimbursement. Keep in mind, when you go to an out-of-network provider, your coinsurance will be higher and you will have to pay the doctor 100 percent of the amount above the maximum reimbursable charge. In some cases, you may have to prepay the full amount at the time of service.

When You Need Laboratory Services

To ensure the highest level of benefit, ask your doctor to send lab tests to an in-network provider. Remember, any lab tests and screenings that are preventive care services, must be sent to an in-network provider to be paid as preventive care. You are responsible for ensuring that an in-network provider is used. You will be responsible for any amounts above the maximum reimbursable charge for services with an out-of-network provider. If lab tests and screenings are sent to an out-of-network provider, benefits will be paid at the out-of-network level, and you will be responsible for any amounts above the maximum reimbursable charge.

When You Must Be Hospitalized or Need to See a Specialist

If your doctor is in the network, ask to be referred to specialists or hospitals in the network so you'll receive higher benefit levels. If you visit a doctor who is not in the network, your costs will be higher.

Remember, that you must call Cigna before any hospital, skilled nursing and convalescent or rehabilitation facility inpatient admission to precertify your stay. You must also call Cigna to precertify inpatient mental health care or substance abuse treatment. If you don't precertify when required, you'll be penalized. (See the Precertification pages of this section.)

When a Network Provider is not Available

If you live in an area where there are limited network providers that can provide a specialized, medically necessary service you require, you may be able to receive the network reimbursement levels from a provider outside the network. Such care is subject to Maximum Reimbursable Charge limits even if benefits are paid at the network level.

All outpatient care must be requested by the member and approved by CIGNA prior to the services being delivered. To become approved, you must call CIGNA and request a network provider.

All inpatient care must be requested by the member and approved by CIGNA before care is received from a facility outside the network. This does not apply to emergency services.

Standards for Determining Network Availability

CIGNA's standard for determining in-network availability is two in-network providers in the applicable access area. For hospitals, the standard is one in-network hospital in the applicable access area.

For primary care physicians, the standards include the following:

- in urban areas, two primary care physicians within 10 miles
- in suburban areas, two primary care physicians within 15 miles
- in rural areas, two primary care physicians within 25 miles

For specialist, the standards include the following:

- in urban areas, two specialty care doctors within 15 miles
- in suburban areas, two specialty care doctors within 20 miles
- in rural areas, two specialty care doctors within 30 miles

For hospitals, the standards include the following:

- in urban areas, one hospital within 25 miles
- in suburban areas, one hospital within 30 miles
- in rural areas, one hospital within 35 miles

Surprise Medical Bills

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency Services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, the federal phone number for information and complaints is: 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

If you believe you've been wrongly billed by an out-of-network provider, you should contact CIGNA immediately using the number on the back of your ID card or the number on your Explanation of Benefits (EOB).

Medical Options Definitions and Rules

Annual Deductible

The annual deductible is the amount of money you pay each year before the plan begins to pay benefits for medical expenses. Once the annual deductible is met, if applicable, the plan pays a share of the cost of most covered medical expenses—and you pay the rest. The in-network expenses will not count towards the out-of-network deductible. Any out-of-network expenses will count towards the in-network deductible.

$1,000 and $4,000 Deductible Options

In these options, once one individual family member meets the "individual in a family" deductible, the plan will begin saying costs for that family member only. Once the family deductible is met, all covered members will be considered to have met their individual deductibles for the year. However, no one person can contribute more than the equivalent of one individual deductible toward the family deductible.

Copays, non-compliance penalties, prescription drug expenses, expenses not covered by the plan, and charges in excess of the maximum reimbursable charge do not accumulate towards your deductible.

For the $4,000 deductible option only, prescription drug expenses will count towards your deductible. However, any additional penalty charges relating to prescription drug coverage will not count towards your deductible. For the $1,000 deductible option, the deductible does not apply to prescription drug expenses.

$2,0000 and $3,000 Deductible Options

If you have family coverage, the individual deductible does not apply. Instead, you have a "true" family deductible. This means you must meet the entire family deductible before the plan begins to pay benefits for any covered family members. Once the family deductible is met—by one or more individuals in the family—the plan begins paying benefits. Remember, if you cover any person in addition to yourself, including for example a domestic partner or a dependent child, you will have family coverage, and the family deductible will apply.

Non-compliance penalties, expenses not covered by the plan, and charges in excess of the maximum reimbursable charge do not accumulate towards your deductible. Prescription drug expenses will count towards your deductible. However, any additional penalty charges relating to prescription drug coverage will not count towards your deductible.

Annual Out-of-Pocket Limit

The annual out-of-pocket limit is the maximum amount that you and your family have to pay for covered medical expenses in a year. The out-of-pocket limit protects you against having to pay extraordinary medical bills for covered expenses in a given year. The annual deductible, copays, coinsurance and prescription drug expenses count toward the out-of-pocket limit for all of the medical options. Expenses not covered by the plan, non-compliance penalties, and charges above the maximum reimbursable charge are not counted toward the out-of-pocket limit.

If you elect family coverage, and the expenses paid in coinsurance for one family member reach the "individual within a family" out-of-pocket maximum, the plan will pay 100 percent of only that family member's eligible expenses for the rest of the year. If eligible expenses paid in coinsurance for all family members combined reach the family out of pocket maximum, the plan will pay 100 percent of all eligible expenses for the rest of the year for all enrolled family members.

In-network expenses will not count toward the out-of-network limit. Out-of-network expenses will count toward the in-network limit.

Maximum Reimbursable Charge

Maximum reimbursable charges (sometimes called the reasonable and customary amount) are charges that are within the normal range of fees as determined by Cigna below. They are used when there is no negotiated discounted rate available. Reimbursement for expenses incurred when you don't use a network provider is based on the maximum reimbursable charge for the treatment or service you receive. Maximum reimbursable charge limits do not apply to network charges since network providers have agreed to already reduced fees for their services. You pay a share of these pre-negotiated fees.

The maximum reimbursable charge is determined based on the lesser of:

- The provider's normal charge for a similar service or supply; or
- 200% of a fee schedule developed by CIGNA that is based upon a methodology similar to the methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

Note: In some cases, a Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is determined based on the lesser of:

- The provider’s normal charge for a similar service or supply; or
- The charges made by 80% of the providers of such service or supply in the geographic area where it is received as compiled in a database selected by CIGNA.

If your provider charges more than the maximum reimbursable charge as determined by Cigna, you will be responsible for paying the additional amount. These additional amounts will not count toward your deductible or your out-of-pocket limit. You may want to discuss charges that are above the maximum reimbursable charge with your doctor or hospital to be certain that the bill is correct and complete.

Precertification

The plan only covers treatment that is medically necessary. The plan requires that certain procedures and treatments be certified by Cigna before being rendered to ensure medical necessity. In some emergency situations, certification can occur following the treatment. Further, precertification is not required for certain minimum hospital stays following the birth of a child.

You must call Cigna at 1.800.244.6224 to precertify. Precertification requirements include but are not limited to the items set forth in this section.

The following are general inpatient medical services requiring precertification:

- Non-emergency hospital inpatient admissions
- Skilled nursing admissions
- Convalescent admissions
- Rehabilitation facility admissions
- Transfers between inpatient facilities
- All other inpatient admissions and stays
- Experimental and investigational procedures
- Cosmetic procedures
- Maternity stays longer than 48 hours (normal delivery) or 96 hours (Cesarean)

The following are general outpatient medical services requiring precertification:

- Outpatient surgery
- High tech radiology (MRI, CAT scan, PET scan)
- Injectible drugs (other than self-injectibles)
- Durable medical equipment
- Home health care
- Home infusion therapy
- Dialysis (to direct to participating facilities)
- External prosthetic appliances
- Biofeedback
- Speech therapy
- Cosmetic or reconstructive procedures
- Infertility treatment

You must follow certain precertification procedures to avoid strict financial penalties. It is your responsibility to make sure either you or your doctor calls:

- At least one week before any non-emergency hospital, skilled nursing, convalescent or rehabilitation facility admission to precertify the admission
- Within 48 hours after you are admitted to the hospital in the case of an emergency. A family member or doctor may call for you. You only have to call if you are admitted to the hospital, not if you visit the emergency room and are released the same day.
- If your doctor wants to extend your hospital stay. It is up to you or your family to make sure that either your doctor or the hospital calls Cigna to precertify the extension.

If you don't properly and timely follow the precertification procedures, the following penalties may apply:

- $400 penalty applied to the charges.
- Benefits are denied for any admission or outpatient service reviewed by Cigna and not certified.
- Benefits are denied for any additional days not certified by Cigna.

Any unpaid expenses will be your responsibility and will not count toward your deductible or annual out-of-pocket maximum.

No Assignment of Rights and Benefits

Your rights and benefits under a medical option are personal to you and your enrolled family members and they cannot be assigned, sold or transferred (in whole or in part) to any person, including your health care provider. For this purpose, your plan rights and benefits include, without limitation, the right to file an administrative appeal (internal and external), the right to sue following a denied administrative appeal and any other plan rights and ben-

efits, whether actual or potential. Any purported assignments of rights and/or benefits under the plan will be void and will not apply to the plan. Further, a payment or reimbursement of covered services by a claims administrator to a health care provider will not waive the application of this provision. The application of this provision does not affect your right to appoint an authorized representative.

The provisions in this section –

- Are deemed to be notice to any and all individuals to whom notice may be required, and no additional notice of the above provisions is needed to anyone, including a health care provider;
- Shall apply at all times, including before and after health care services are rendered or the health care products are provided (as applicable);
- Are not waivable, in whole or in part, whether voluntarily or involuntarily, by the plan, the plan administrator or a claims administrator; and
- May be raised as a defense to a payment or reimbursement at any time, including after the conclusion of the claim and appeal process.

Limited Authorization of Payments and Health Care Provider Agreements

To the extent allowed by the claims administrator, you may authorize your claims administrator to make payments directly to a health care provider for covered services. Further, even without such authorization, a claims administrator may make direct payments to a health care provider for covered services according to the claims administrator's rules and procedures at the applicable time. Authorization of payments to a health care provider or direct payments to a health care provider are not assignments of benefits. Even though you may authorize a health care provider to receive a payment or reimbursement of covered services and even though a claims administrator may pay a health care provider directly for payments or reimbursements of covered services, in no event will any such authorizations, payments or reimbursements to or on behalf of a health care provider cause the provider to become a plan participant or plan beneficiary (or assignee of a participant or beneficiary) under ERISA.

In addition, sometimes your health care provider requests that you sign various agreements and other documentation as a condition of receiving health care services from the provider. Any agreement, assignment or other document executed by you and a health care provider (or executed by parties that include you and a health care provider but that do not include the plan administrator or the Company) are not binding on and will have no legal effect whatsoever on any terms, conditions or requirements of the plan or any claims administrator. Further, a payment or reimbursement of covered services by a claims administrator to a health care provider (whether pursuant to an authorization or otherwise) will not waive the application of this provision.

The provisions in this section –

- Are deemed to be notice to any and all individuals to whom notice may be required, and no additional notice of the above provisions is needed for anyone, including a health care provider;
- Shall apply at all times, including before and after health care services are rendered or the health care products are provided (as applicable);
- Are not waivable, in whole or in part, whether voluntarily or involuntarily, by the plan, the plan administrator or a claims administrator; and
- May be raised as a defense to a payment or reimbursement at any time, including after the conclusion of the claim and appeal process.

Authorized Representative Rules

If you need to appoint an authorized representative for purposes of an internal claim or appeal for health and welfare benefits or for purposes of an external appeal for medical benefit claims, you must follow the rules and procedures of the applicable Claims Administrator for such claim or appeal. To the extent a Claims Administrator has no rules or procedures, then the rules and procedures of this section will apply.

If you need to appoint any authorized representative for any purpose other than as listed in the prior paragraph, your appointment of an authorized representative must:

- Be in writing and dated,
- Clearly indicate the authorized representative, the scope of the appointment and any limitations on the authorized representative,
- Be signed by you, and must be notarized by a notary public,
- Satisfy any other legal requirement applicable to appointments under state or federal law, AND
- Be approved by the Plan Administrator in writing.

A plan will also recognize a court order appointing a person as your authorized representative. The Plan Administrator may also provide different rules and procedures for an appointment of an authorized representative in emergency situations or for attorneys.

Appointing an individual or entity as your authorized representative is not an assignment of rights or benefits under the Plan and any such appointment (whether pursuant to the rules of a Claims Administrator or the Plan Administrator) does not waive the Plan's anti-assignment provisions.

Covered Medical Expenses

The medical plan options cover only medically necessary services and supplies your doctor prescribes or authorizes to treat an illness or injury. Certain expenses, such as those incurred for hospitalization, must be pre-certified before benefits are paid by the Plan.

Other expenses, such as preventive care services, must be provided by in-network physicians. See medical plan option chart on previous pages to determine the applicable coinsurance, copays and other terms and conditions.

Covered medical expenses include:

Preventive Care

The following preventive care is covered only when you use an in-network doctor or provider:

- *Well-Care:* Unlimited well-care up to age two for your covered dependents, covered at 100 percent with no deductible.
- *Annual Exams:* After age two one routine physical and one routine gynecological exam for you and your covered dependents each year, covered at 100 percent with no deductible. Deductibles do not apply to these exams. Routine lab work is also covered at 100 percent with no deductible.
- *Screenings:* Routine mammograms (beginning at age 40), pap smears, prostate and colon screenings covered at 100 percent (when provided during an office visit) with no deductible. Special screenings for women are also covered as preventive care. All screenings are covered based on American Medical Association (AMA) and other applicable guidelines. Any associated services and consultations in conjunction with these tests other than the yearly physical will be subject to deductible and coinsurance. Diagnostic screenings (non-routine) are covered as medically necessary and subject to applicable deductible and coinsurance.
- *Breast Feeding Support, Supplies and Counseling:* Breast feeding support (lactation support), breast feeding supplies (rental of breast pump) and related counseling are covered at 100 percent. Claims must be related to a birth of a child, prescribed by a physician, and be within the guidelines established by Cigna.
- *Contraception and Related Counseling:* Generic prescription contraceptives, brand-name contraceptives when a generic is not available or is medically necessary, and various contraceptive medical devices will be covered at 100%. Associated office visits for the administration of contraceptive devices (i.e., contraceptive devices such as Depo-Provera, Intrauterine Devices (IUDs) and Diaphragms as ordered or prescribed by a physician) will also be covered at 100%, subject to Cigna guidelines. Office visits for contraceptive counseling will be covered at 100 percent, subject to limitations imposed by Cigna.
- *Immunizations:* All childhood and adult immunizations recommended by the AMA are covered at 100 percent.

A full list of preventive care items and services may be found at http://www.healthcare.gov/center/regulations/prevention.html. If a preventive care item or service in the website listing or as described above does not specify a limitation on the frequency, method, treatment or setting, the plan may apply reasonable limitations and other medical management requirements. Contact Cigna for additional information.

Emergency

In an emergency, get the care you need immediately. If you experience a sudden and unexpected change in your physical or mental condition that is severe enough to require immediate care, go to the nearest hospital (whether or not the hospital is in the network).

If you are admitted to the hospital and stay overnight, you must call Cigna within 48 hours of the admission to ensure that no penalty will apply to your stay. Your doctor or a family member may call on your behalf. It is not necessary to call Cigna if you visit the emergency room and are discharged the same day. If you are admitted to a hospital for mental health or substance abuse treatment and stay overnight, you must call Cigna within 48 hours of the admission to ensure that a penalty will not apply and that you have coverage.

In determining whether an ER visit is an emergency, the plan will apply the emergency services requirements under applicable federal law. Under these requirements, a true emergency room visit will be a visit for a medical condition with acute symptoms of sufficient severity (including severe pain) so that a reasonable person, who possesses an average knowledge of medicine, could reasonably be expected to go to the emergency room.

In the case of a surprise bill from an out-of-network provider, where you had no control over their participation in your covered services, you will pay the same cost share you would have if the covered services were received from a network provider. The cost share will be based on the median contracted rate. Review the section entitled, “Surprise Medical Bills” and contact CIGNA for additional information.

Mental Health and Substance Abuse Treatment

The plan covers mental health and substance abuse treatment, subject to the usual deductibles, coinsurance, and maximums. All care must be medically necessary to be considered an eligible expense. Inpatient care must be precertified by Cigna. Mental health and substance abuse services are those covered services for which you obtain care from a behavioral health or mental health provider, based on applicable guidelines and requirements of Cigna.

Outpatient services received from a primary or specialty physician are treated and paid as regular office visits.

Note: The Employee Assistance Program (EAP) also covers counseling visits at no charge. You may use either or both the EAP or the mental health services provided by the medical plan. See the EAP SPD section for more information.

Mastectomy Treatments

The Women's Health and Cancer Rights Act requires group health plans that cover medically necessary mastectomies to cover:

- Breast reconstruction (for the breast that required the mastectomy)
- Reconstruction of the other breast (to produce a symmetrical appearance)
- Prostheses
- Treatment of physical complications

Expenses related to the above are subject to the usual deductibles and coinsurance associated with the plan. This coverage will be determined in consultation with the attending physician and patient.

Maternity and Newborn Children

Pregnancy benefits are payable for employees and Spouses/Domestic Partners. There is no coverage for dependent children.

Benefits for pregnancy are paid in the same way as benefits are paid for sickness, including birth center services (room and board, anesthetics and other services and supplies); nurse-midwife's services (if licensed or certified); and routine well-baby care (hospital services for nursery care, other hospital services and supplies, services of a surgeon for circumcision and physician services — provided during the newborn's initial hospital confinement).

In accordance with federal law, the plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (96 hours as applicable). Nor is it required that a provider obtain authorization from the administrator(s) for prescribing a length of stay not in excess of the above periods.

The plan pays eligible benefits for a newborn child starting at delivery. You must enroll the newborn child within 31 days of the date of birth – otherwise you will have to wait until the next annual enrollment period, or other qualifying change in status, if earlier.

Physical, Speech, Vision and Occupational Therapy

Physical, speech, and occupational therapy are covered when the therapy is expected to result in the improvement of a body function, including the restoration of the level of an existing speech function, which has been lost or impaired due to an injury, illness or congenital defect. This includes services incurred in association with infantile autism, development

delays, or cerebral palsy, hearing impairment or major congenital abnormalities. This therapy is covered as a medical benefit, based on the applicable guidelines and requirements of Cigna.

A treatment recommendation from your doctor does not mean that the treatment will be covered under the plan. In some circumstances, Cigna will determine that the recommended care is not medically necessary and coverage may be denied.

This therapy is provided as part of an approved Home Health Care Plan and therapy days accumulate to the applicable outpatient short term rehab therapy maximum . Physical, speech and occupational therapy is limited to 60 days per person, per year.

Skilled Nursing Care

The plan covers charges made by a R.N. or L.P.N. or a nursing agency for skilled nursing care, as follows:

- Visiting nursing care by a **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.
- Private duty nursing by a **R.N.** or **L.P.N.** if the person's condition requires skilled nursing services and visiting nursing care is not adequate.

Benefits will not be paid during a calendar year for private duty or special duty nursing in excess of 70 days per calendar year. The maximum number of hours per day is limited to 8 hours. Skilled nursing care is not covered unless pre-authorized by Cigna.

Not included as “skilled nursing care” is:

- that part or all of any nursing care that does not require the education, training, and technical skills of a **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs, and companionship activities; or
- any private duty nursing care given while the person is an inpatient in a **hospital** or other health care facility; or
- care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
- care provided solely for skilled observation except as follows: for no more than one 4 hour period per day for a period of no more than 10 consecutive days following the occurrence of: change in patient medication; need for treatment of an emergency condition by a physician or the onset of symptoms indicating the likely need for such treatment; surgery; or release from inpatient confinement; or any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by a **R.N.** or **L.P.N.**

Alternative Care Settings

At times, care can be delivered more comfortably and cost-effectively in an alternative setting such as a **skilled nursing facility**, rehabilitation facility, your home or a **hospice**. The Plan limits the number of visits and/or days of care for which it will pay, as described in the previous coverage chart

Skilled Nursing Facilities/Convalescent Facilities

Charges made by a convalescent facility for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury. The confinement must start during a "Convalescent Period".

Covered expenses include:

- room and board (limited to the facility's regular daily charge for a semi-private room);
- use of special treatment rooms;
- x-ray and lab work;
- physical, occupational or speech therapy;
- oxygen and other gas therapy;
- other medical services usually given by a convalescent facility. This does not include private or special nursing, or physicians services; and
- Medical supplies.

Benefits will be paid for up to a 120 day maximum per calendar year for skilled nursing facility, rehabilitation hospital or sub-acute care facility. This starts on the first day a person is confined in a convalescent facility if he or she:

- Was confined in a hospital for at least 3 days in a row, while covered under this Plan, for treatment of a disease or injury; and
- Is confined in the facility within 14 days after discharge from the hospital; and
- Is confined in the facility for services needed to convalesce from the condition that caused the hospital stay. These include skilled nursing and physical restorative services.

It ends when the person has not been confined in a hospital, convalescent facility, or other place giving nursing care for 90 days in a row.

This section does not cover charges made for treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Alcoholism.
- Senility.

- Mental retardation.
- Any other mental disorder.

Home Health Care

Home health care expenses are covered if:

- The charge is made by a home health care agency; and
- The care is given under a home health care plan; and
- The care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Plan if the person had been confined in a hospital or convalescent facility:
    - Medical supplies;
    - Drugs and medicines prescribed by a physician; and
    - Lab services provided by or for a home health care agency.

The maximum number of home health care visits is 120 days per person per year. The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 8 hours or less (e.g., maximum of two visits per day).

Limitations to Home Health Care Expenses. This section does not cover charges made for:

- Services or supplies that are not part of the home health care plan.
- Services of a person who usually lives with you or who is a member of your or your wife's or husband's family.
- Services of a social worker.
- Transportation

Hospice Care

Charges made for the following furnished to a person for Hospice Care when given as a part of a Hospice Care Program are included as Covered Medical Expenses.

Facility Expenses

The charges made in its own behalf by a:

- Hospice facility;
- Hospital; or
- Convalescent facility.

Which are for:

- Board and room and other services and supplies furnished to a person while a full-time inpatient for:
  - Pain control; and
  - Other acute and chronic symptom management.
- Not included is any charge for daily board and room in a private room over the Private Room Limit.
- Services and supplies furnished to a person while not confined as a full-time inpatient.

Charges made by a Hospice Care Agency for:

- Part-time or intermittent nursing care by a R.N. or L.P.N. for up to 8 hours in any one day.
- Medical social services under the direction of a physician. These include:
  - Assessment of the person's social, emotional and medical needs; and
  - The home and family situation;
  - Identification of the community resources which are available to the person; and
  - Assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a physician.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a physician.
- Bereavement counseling.

Charges that are not covered include:

- funeral arrangements;
- pastoral counseling;
- financial or legal counseling. This includes estate planning and the drafting of a will;
- homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; house cleaning; and maintenance of the house;

- respite care. This is care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Transplants

The Plan covers charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations noted in this section.

Transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

All transplant services, other than cornea, are covered at 100% when received at CIGNA LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at CIGNA LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with CIGNA for those transplant services, other than CIGNA LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including non-participating providers and participating providers not specifically contracted with CIGNA for transplant services, are covered at the Out-of-Network level.

If you do not use a CIGNA LIFESOURCE facility, benefits will be paid for a percentage of eligible expenses after you meet your deductible — based on your medical option — subject to an *additional* out-of-pocket limit of $10,000 before the Plan starts paying benefits. This means you must meet *both* the regular out-of-pocket limit and this additional out-of-pocket limit before benefits are paid at 100% of covered expenses.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for trans-

portation, lodging and food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

The following are specifically excluded travel expenses – travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

You must contact Cigna to precertify your transplant or related procedures.

A travel lifetime maximum of $10,000 per transplant applies regardless of the facility in which the transplant is performed.

Oral Surgery and Dental Services

The Plan covers oral surgery (limited to extraction of bony, impacted teeth, treatment of bone fractures, removal of tumors and orthodontogenic cysts).

Oral surgery is covered if it is a necessary, but incidental, part of a larger service treating a covered, underlying medical condition (including temporomandibular joint syndrome (“TMJ”) and orthodontia-related services when medical in nature).

The following services and supplies are covered only if they are needed because of accidental injury (excluding chewing accidents) to natural teeth for a continuous course of dental treatment started within six months of an injury to sound, natural teeth:

- oral surgery;
- full or partial dentures;
- fixed bridge work;
- prompt repair to natural teeth; and
- crowns.

This coverage is secondary to any group dental plan.

Infertility Treatment

Plan coverage is provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services are covered as any other illness.

However, infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees) are not covered. Cryopreservation of donor sperm and eggs are also excluded from coverage.

Durable Medical Equipment

Durable medical equipment means equipment:

- for repeated use;
- used primarily for a medical purpose; and
- appropriate for use in the home.

Rental of durable medical and surgical equipment is a Covered Medical Expense.
In lieu of rental, the following may be covered:

- The initial purchase of such equipment if Cigna is shown that: long-term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.
- Repair of purchased equipment.
- Replacement of purchased equipment if Cigna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

Durable medical or surgical equipment purchased through a pharmacy will receive the pharmacy discounts. You will be required to file a claim through the medical plan to receive reimbursement.

Foot Care

The plan does not cover 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.

Physician Services

Medical care and treatment:

- hospital, office and home visits; and
- emergency room services.

Services for surgical procedures to improve the function of a body part when the malfunction is the direct result of one of the following:

- birth defect;
- sickness;
- surgery to treat a sickness or accidental injury;
- accidental injury;
- reconstructive breast surgery following a medically necessary mastectomy; or
- reconstructive surgery to remove scar tissue on the neck, face or head if the scar tissue is due to sickness or accidental injury.

Other Covered Medical Expenses

Gender Reassignment Surgery and Related Services

The Equifax medical options will cover services in connection with a medically necessary gender reassignment surgery, including pre- and post-surgical hormone therapy. These services will be covered as follows –

- The applicable deductible and co-insurance will apply,
- The services must be medically necessary and must be services related to gender reassignment surgery, both as determined by CIGNA based on its current guidelines and policies applicable to the services,
- Coverage will apply to covered employees, covered spouses and other covered dependents, provided that the services are medically necessary, based on the current guidelines and policies of CIGNA,
- All services must be pre-certified by CIGNA, and
- Services that are determined to not be medically necessary by CIGNA, based on its current guidelines and policies, will not be covered.

If you have any questions regarding medically necessary covered services, please contact CIGNA.

Other Covered Services

Each medical plan option has a separate Cigna Healthcare Benefit Summary posted on People Link. You should review the summary for your medical plan option if an expense is

not listed in prior pages. The applicable summary will apply to the extent of any differences between the applicable summary and the listing of covered medical expenses on the previous pages.

Other covered medical expenses include the following if medically necessary and not experimental or investigational (some of the following items are discussed in more detail in prior sections of this SPD) –

- X-ray, radium and radioactive isotope therapy.
- Anesthetics and oxygen.
- Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first hospital where treatment is given.
- Artificial limbs and eyes.
- Ambulatory surgical center.
- Anesthesia.
- Semi-private room and board (the additional costs for a private room are covered only if the private room is medically necessary).
- Pre-admission testing.
- Allergy treatment/injections
- Prostate testing (PSA).
- X-ray, radium, radio, isotope treatments.
- Chemotherapy.
- Blood transfusions and blood not donated or replaced.
- Oxygen and other gases.
- External prosthetic appliances.
- One wig per lifetime for 2nd degree full thickness and 3rd degree burns with resulting permanent alopecia; Lupus; Alopecia areata with near complete or complete cranial hair loss; Alopecia totalis; Alopecia univeralis; Fungal infections not responsive to an appropriate (typically 6 week) course of antifungal treatments resulting in near complete or complete cranial hair loss; Chemotherapy; and Radiation therapy.
- Reconstructive surgery to correct the malfunction of a body part due to birth defect, sickness, accidental injury or surgery to treat a sickness or accidental injury; or re-constructive surgery to remove scar tissue from the neck, face or head if due to sickness or accidental injury.
- Medically necessary dental or vision treatment due to an underlying condition caused by a covered medical condition (including temporomandibular joint syndrome (“TMJ”) and orthodontia-related services when medical in nature). This coverage is secondary to any group dental or vision plan.
- Purchase of hearing aids are covered up to $10,000, once every two years

Expenses not Covered

The medical plan options cover only treatments, services or supplies that are determined by Cigna to be medically necessary, effective and recommended by the attending physician. **Expenses that are not covered include:**

- acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery;
- expenses that exceed reasonable and customary limits or the maximum reimbursable charge;
- services, supplies or treatments not determined to be medically necessary, including any related confinement;
- expenses covered under any Workers' Compensation Act or similar legislation;
- expenses that would not have been incurred if no coverage existed;
- services or supplies available or provided due to service in the armed forces of any government and any expenses incurred while serving in the armed forces of any government;
- cosmetic surgery or treatment (unless performed to correct a deformity caused by an injury) or reconstructive surgery that is not medically necessary following surgery (unless required by the Women's Health and Cancer Right Act regarding the coverage for reconstructive surgery related to mastectomy);
- dental treatment, except as noted under covered services;
- oral surgery, except as noted under covered expenses;
- herbal, holistic or homeopathic care or medicines; ecological or environmental medicine, diagnosis and/or treatment;
- abdominoplasty (cosmetic surgery of the abdomen);
- breast reduction surgery (unless determined to be medically necessary);
- chelation therapy (except for treatment for Biliary cirrhosis; Cooley's anemia (thalassemia major); Cystinuria; heavy metal poisoning; Wilson's disease; Sickle Cell anemia' and Secondary hemochromatosis (i.e. due to iron overload from multiple transfusions);
- liposuction;
- charges for procedures which facilitate a pregnancy but do not treat the cause of infertility (such as in vitro fertilization, artificial insemination, ovul induction, advanced reproductive technology, GIFT, etc.);
- services provided by a member of your immediate family (including parents, grandparents, siblings or children of either you or your spouse/domestic partner);
- speech (except noted under eligible expenses) and physical therapy for treatment of development delays, mental retardation, or learning disabilities;
- eyeglasses;
- hearing exams;
- **custodial care**, education or training;
- Educational services, special education, remedial education or job training:
    - The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training or cognitive rehabilitation. Services, treatment, and educational testing

and training related to behavioral (conduct) problems, learning disabilities and developmental delays are not covered by the Plan;

- Immunizations related to travel or work (other than COVID-19 immunizations);
- procedures to correct vision impairment;
- experimental, investigational or unproven services
- services or supplies provided before coverage is in effect or after coverage is terminated;
- charges for missed appointments and completing claim forms;
- services and supplies which you are not legally required to pay;
- examinations or treatment ordered by a court in connection with legal proceedings, unless such examinations or treatment otherwise qualify as covered services;
- care not provided under the supervision of a physician (or other qualified provider) operating within the scope of his or her license;
- treatment for an injury resulting from your commission or attempted commission of a felony or violent crime;
- private duty nursing services while confined in a facility;
- reversal of sterilization;
- stand-by services required by a physician;
- telephone consultations;
- membership costs for health clubs, weight loss clinics and similar programs;
- Bariatric surgery unless approved by CIGNA as medically necessary;
- weight reduction or control (unless there is a diagnosis of morbid obesity and approved by CIGNA);
- special foods, food supplements, liquid diets, diet plans or any related products;
- services by a pastoral counselor;
- services related to the removal of an organ or tissue for transplant, unless the transplant recipient is a covered person under this Plan and is undergoing a covered transplant;
- hair transplants, hair weaving or any drug used in connection with baldness;
- services given by volunteers or persons who do not normally charge for their services;
- massage therapy;
- autopsies;
- expenses that are payable by Medicare Part A or Part B regardless of whether you have enrolled in Medicare Part A or Part B;
- charges for or related to the fertility treatment or pregnancy of a surrogate mother;
- expenses related to the storage of your health care information or data; and
- any excluded expenses listed in your medical option's Cigna Healthcare Benefit Summary, posted on People Link.

Some state or local laws may restrict the (1) scope of health care services that a physician may render and/or (2) the scope of health care items that a physician may prescribe or furnish. In such case, the Medical Options will not cover such health care services or health care items. The Plan (and each applicable Medical Option) does not cover, pay for or reimburse health care services or health care items that are prohibited by state or local law and which are illegally performed, prescribed or furnished in such state or locality.

Experimental, Investigational or Unproven Services

Experimental, investigational or unproven services are medical, surgical, diagnostic, psychiatric, substance abuse, prescription drugs and other health care technologies, supplies, treatment, procedures, drug therapies or devices that are determined by Cigna to be –

- Not demonstrated through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; OR
- Not approved by the US Food and Drug Administration or other appropriate regulatory agency to be lawfully marketed for the proposed use; OR
- The subject of an ongoing clinical trial (other than approved clinical trials discussed below).

Experimental, investigational or unproven services do not include “routine patient costs” of a “qualified individual” related to “approved clinical trials”.

Approved Clinical Trials

The medical options cover routine patient costs for items or services incurred by a qualified individual in connection with participation in an approved clinical trial. The plan may not deny (or limit or impose additional conditions on) the coverage of routine patient costs for any items or services furnished in connection with participation in an approved clinical trial.

Routine patient costs include all items and services that would be covered typically under the medical option for individuals who are not otherwise participating in a clinical trial. Routine patient costs for items and services to diagnose or treat complications or adverse events arising from participation in an approved clinical trial are items and services furnished in connection with participation in an approved clinical trial, and accordingly, are required to be covered in accordance with Federal law, if the plan typically covers such items or services for a qualified individual who is not enrolled in a clinical trial.

Routine patient costs do not include any of the following:

- The investigational items, devices or services being studied in the approved clinical trial;
- Items or services that are provided solely to satisfy clinical trial data collection and analysis needs and that are not used in the direct clinical management of the patients;
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Any benefits for routine patient care services provided by an out-of-network provider unless out-of-network benefits are otherwise covered under the applicable medical option.

To be a qualified individual, you must be eligible to participate in an approved clinical trial, and your attending physician must determine that your participation in the trial is appropriate. Or, you must provide medical or scientific information establishing that you meet the eligibility standards of the trial protocol and that your participation in the trial is appropriate.

An approved clinical trial is a phase I, II, III or IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition (i.e., likely to lead to death unless the course of the disease or condition is interrupted), and is any one of the following:

- Federally funded by one of more government agencies or entities designated in Section 2709(d)(1)(a) of the Public Health Service Act;
- Conducted under an investigational new drug application reviewed by the FDA; or
- Is a drug trial that is exempt from the investigational new drug application requirements.

- **Who to Contact**

If you have a question about whether a service or supply is covered, contact Cigna using the number located on your ID Card.

Additional Health and Wellness Benefits

Online Doctor Visits – MDLIVE

MDLIVE from CIGNA allows you to get the medical care and prescription drugs for many non-emergency situations without leaving your home.

Obtain medical care and prescriptions for many non-emergency situations, such as pink eye, allergies, flu, nausea, urinary tract infections and more.

You can also obtain support for addictions, depression, grief and loss, LGBTQIA support, relationship and marriage issues.

You can connect with board-certified doctors, nurses and therapists 24/7 via phone, email or video.

Call 888-726-3171. You may also visit www.myCigna.com, locate the “Talk to a Doctor or Nurse 24/7” callout and click “Connect Now.”

Download the app on Google Play or the iTunes App Store.

Health Matters

Health Matters is an interactive health assessment tool that connects you with personalized information and tools to help you take charge of your wellness goals. You can –

- Discover personalized recommendations to keep you on target for wellness.
- Track important health information, like your BMI, cholesterol and more.

Health Matters is found on www.mycigna.com under the wellness tab, under tools and select my health assessment.

Omada

Omada provides you with help managing chronic disease.

It is a digital wellness program for employees and family members who are pre-diabetic or at risk for heart disease. There is no cost to participate for adults who are enrolled in an Equifax medical option, are at risk for type 1 or type 2 diabetes or heart disease, and are accepted into the program.

If you qualify, you can receive full-time health coaching, access to programing and more. You will even get a wireless smart scale and digital pedometer.

See www.omadahealth.com/equifax for additional information.

Grand Rounds

Grand Rounds is a new complimentary health care benefit for employees and dependents who are covered by an Equifax medical option. It provides expert medical guidance and support to help ensure you always receive the best health care possible.

Grand Rounds works with the top doctors and specialists in the country. You can use Grand Rounds anytime, but especially if –

- You need a second opinion on a new or long-term health issue or treatment plan.
- You need personalized advice about recommendations your doctor has made.
- You were recently diagnosed and need to see an expert about your condition.
- You've recently moved and need to find a specialist near you.

Grand Rounds is provided at no cost by Equifax to you and your enrolled dependents.

To learn more, visit www.grandrounds.com/equifax or call 1-855-394-2218 from 8:00 am to 9:00 pm ET.

Download the app on Google Play or the iTunes App Store.

Prescription Drugs

Prescription drug benefits are provided by Cigna. The medical options pay benefits for medically necessary outpatient prescription drugs. Prescription drugs which are provided as an inpatient (e.g., in a hospital setting) are paid as a medical expense, and not covered under the prescription drug program.

The Plan Administrator reserves the right at any time to exclude any particular drug or drug class, to place limits on the quantity of any particular drug or drug class that may be purchased and to limit the pharmacies at which a particular drug or drug class may be purchased.

Retail Prescription Drugs

You can use your ID card at participating Cigna pharmacies. You may purchase up to a 30-day supply per prescription. If you do not present your drug card at the pharmacy, you will have to pay the total cost of your prescription and file a claim for reimbursement. You will be reimbursed up to the allowable amount for the prescription, less the applicable coinsurance and sales tax.

Prescriptions filled at a non-participating pharmacy or at a pharmacy that is not within the Cigna network are not covered.

Prescription (up to 30-Day Supply)	$1,000 Deductible*	$2,000 Deductible**	$3,000 Deductible**	$4,000 Deductible**
Generic Preventive Drugs	You pay 20% (no deductible)	No Charge	No Charge	No Charge
All Other Prescription Drugs	You pay 20% (no deductible)	You pay 10% (after deductible)	You pay 20% (after deductible)	You pay 30% (after deductible)

* Coinsurance for prescription drugs do not count towards your annual medical deductible, but will count toward the medical out-of-pocket maximum.
** Eligible prescription drug expenses accumulate toward the medical deductible and out of pocket maximum.

Special Rules

- Generic prescription drug contraceptives (and brand name contraceptives that are medically necessary as determined by your doctor or when no generic is available) are paid at 100% with no deductible.
- Prescription drugs that are excluded from Cigna's preferred and non-preferred lists are not covered.
- If you buy a brand name when a generic equivalent is available, you'll pay the applicable coinsurance, plus the cost difference between the generic and the brand-name. Further, this extra cost does not accumulate toward your deductible, does not accumulate toward your out-of-pocket maximum. However, brand-name contraceptives, if the brand name is medically necessary, are covered at 100 percent.
- For maintenance medications, after three 30-day fills at a retail pharmacy, you must fill your prescription through mail order – otherwise you will pay the entire cost of the prescription.

Mail Order or Retail Pharmacy 90-Day Supply Program

You also have the option of using Cigna's Home Delivery mail order prescription drug program. Up to a 90-day supply of a prescribed maintenance drug (a drug used on an ongoing basis) such as high blood pressure medication or birth control pills can be purchased through mail order. Whenever possible, your prescription will be filled with a generic equivalent. Further, you can obtain a 90-day supply through select network pharmacies. You should ask your retail pharmacy if they can provide a 90-day supply.

Prescription (up to 90-Day Supply)	$1,000 Deductible*	$2,000 Deductible**	$3,000 Deductible**	$4,000 Deductible**
Generic Preventive Drugs	You pay 20% (no deductible)	No Charge	No Charge	No Charge
All Other Prescription Drugs	You pay 20% (no deductible)	You pay 10% (after deductible)	You pay 20% (after deductible)	You pay 30% (after deductible)

* Coinsurance for prescription drugs do not count towards your annual medical deductible, but will count toward the medical out-of-pocket maximum.
** Eligible prescription drug expenses accumulate toward the medical deductible and out of pocket maximum.

Special Rules

- Generic prescription drug contraceptives (and brand name contraceptives that are medically necessary as determined by your doctor or when no generic is available) are paid at 100% with no deductible.
- Prescription drugs that are excluded from Cigna's preferred and non-preferred lists are not covered, unless certain exception rules apply. Contact Cigna to determine whether the exception rules apply to a particular drug.
- If you buy a brand name when a generic equivalent is available, you'll pay the applicable coinsurance, plus the cost difference between the generic and the brand-name. Further, this extra cost does not accumulate toward your deductible and does not accumulate toward your out-of-pocket maximum. However, brand-name contraceptives, if the brand name is medically necessary, are covered at 100 percent.
- Specialty medications must be filled through home delivery, otherwise you pay the entire cost of the prescription after one retail fill (subject to certain exceptions).
- For maintenance medications, after three 30-day fills at a retail pharmacy, you must fill your prescription through mail order – otherwise you will pay the entire cost of the prescription.

Start by getting a short-term supply of your maintenance medication at your local pharmacy. Then take advantage of the benefits of Cigna's Home Delivery by following these two easy steps. The Cigna Pharmacy Mail Order form can be located on People Link.

Step 1: Get a prescription form your doctor for each maintenance medication (typically 90-day supply) that you or a family member is taking. Please write your date of birth and Cigna Member ID on all documents, including prescriptions.
Step 2: Complete and mail a Cigna Home Delivery Order Form along with your new prescription(s) and payment to Cigna.
OR: Call Cigna at 1.800.244.6224, and we will request a prescription from your prescriber for a 90-day supply with refills.

Mail your order to:

Cigna Home Delivery Pharmacy
PO Box 1019
Horsham, PA 19044

Your order will be filled by a licensed pharmacist and delivered to you, postage-paid, within 7-10 days. If you submit insufficient information to process your order, or if Cigna needs to contact your prescribing physician, delivery could take longer.

Ordering refills is easy. There are three methods to choose from:

- Visit www.mycigna.com. Once you log in, you can order refills, track your order and more.
- Call Cigna at 1.800.244.6224. Provide your Cigna Member ID number, your prescription number and your credit card number.
- Complete the Order Form or the Reorder Form and mail with payment in full to the address shown above.

Rules Applicable to all Prescription Drugs

Formulary

Cigna has established a list of "preferred" and "non-preferred" drugs or "formulary". This is a list of prescription medications generally covered under the pharmacy benefit plan subject to applicable limits and conditions. The formulary includes brand-name and generic drugs that have been approved by the FDA as safe and effective. Most drugs are covered at a discounted cost under the Plan. This enables you to further manage or lower your out-of-pocket costs. You can view this list by registering and logging onto www.mycigna.com. You also can contact the Cigna Pharmacy Management Help Line at 1.800.244.6224. Cigna determines the preferred drug and non-preferred drug formulary listing and the Company has no authority or discretion over which drugs are included in the preferred drug and non-preferred drug formulary listing. The preferred drug and non-preferred drug formulary listings are subject to change at any time by Cigna. Drugs that are not listed on the preferred drug or non-preferred drug formulary listings are not covered by the Plan, unless certain exception rules apply. Contact Cigna to determine whether the exception rules apply to a particular drug.

Precertification / Preauthorization

The pharmacy benefits include precertification for certain specialty medications and quantity limits may apply. For example, certain specialty weight-loss drugs are covered by the plan, subject to preauthorization.

Precertification ensures that a drug is medically necessary and part of a specific treatment plan which is based on US Food and Drug Administration (FDA) and manufacturer guidelines, medical literature, safety, and appropriate use of the drug. The Precertification List is subject to change at any time.

Your doctor must contact Cigna to request prior authorization for medications on the Precertification List. If the request is approved, your physician will be notified and the medication will be covered. However, a maximum duration of therapy or quantity limitations may apply.

Step Therapy

Step therapy requires you to try a safe, effective, less expensive drug first. Anticonvulsants, Antidepressants, and Sedatives / Sleep Aids will require Step-Therapy. These drugs often work as well as more expensive drugs but at a lower cost. However, if the "first-line" drug is ineffective, or if it is medically necessary to skip the "first-line" drug, your physician can contact Cigna to request a medical exception. If the request is approved, your physician will be notified, and the drug will then be covered. The Step-Therapy List is subject to change at any time.

In general, the following drug classes or treatments require step therapy. This list is subject to change by Cigna:

- High blood pressure;
- Cholesterol lowering;
- Heartburn / ulcer;
- Bladder problems;
- Osteoporosis;
- Sleep disorders;
- Allergy;
- Depression;
- Skin conditions;
- Mental health;
- Pain relievers;
- ADD / ADHD; and
- Asthma.

Call Cigna at 1.800.244.6224 or visit www.mycigna.com for the current Step-Therapy List.

Quantity Limits

The pharmacy benefits under the medical plans will also include quantity limits for certain medications. Quantity limits are based on recommendations from the manufacturers and the U.S. Food and Drug Administration (FDA), as well as accepted medical practices for dosing. Quantity limits help ensure that you receive the proper dose while minimizing the potential for adverse events and inappropriate therapy. There are three types of quantity limits:

1. Dose Efficiency Edits - Limits coverage of prescriptions to one dose per day for drugs that are approved for once-daily dosing.
2. Maximum Daily Dose - Informational message is sent to the pharmacy if prescription lies outside recommended minimum and maximum doses.
3. Quantity Limits Over Time - Limits coverage of prescriptions to a specific number of units per a defined amount of time.

In order to receive coverage for amounts in excess of the quantity limit, your physician must request a medical exception.

The medications that have quantity limits are subject to change at any time. You can call Cigna at 1.800.244.6224 or visit www.mycigna.com to find which drugs have quantity limits.

Specialty Pharmacy Copay Assistance (SaveonSP)

Certain specialty pharmacy drugs are not one of the ten Essential Health Benefits under the Affordable Care Act, and therefore are not required to be covered by the plan. At the same time, certain drug manufacturers provide financial assistance or coupons to significantly reduce the cost of certain specialty medications.

In order to reduce both the Company's and participant's costs for these specialty drugs, the drugs that are part of a manufacturer financial assistance program (the "Program") will be excluded from coverage under the plan. However, if you enroll in the Program outside of the plan, your out-of-pocket cost after applying the manufacturer financial assistance will be zero or a very small copay. Because the drugs that are part of the Program are excluded from plan coverage, the amount of the manufacturer financial assistance under the Program will not be credited to your deductible or your out-of-pocket maximum. You are also not required to repay any amount of manufacturer financial assistance under the Program.

Most plan participants will not be affected by this change, because they are not taking any of the specialty medications that are part of the Program. There will be approximately 190 specialty medications in 19 therapy classes that will be part of the Program. However, the specialty medications and classes that are part of the Program may change over time.

Participants who are currently taking any of the specialty medications that are part of the Program will also receive a letter explaining the Program and how to enroll. If you are newly prescribed any of the specialty medications that are part of the Program, you will be contacted when you first attempt to fill the prescription and given instructions on how to sign up for the Program.

While it is your choice whether to participate in the Program, if you do not participate in the Program, you will have to pay the full retail cost of the applicable prescription drug. Further, because the applicable drug is not covered by the plan, any cost you would pay would not be credited to your deductible and out-of-pocket maximum.

Prescription Drug Exclusions

Some state or local laws may restrict the (1) scope of health care services that a physician may render and/or (2) the scope of health care items that a physician may prescribe or furnish. In such case, the Medical Options will not cover such health care services or health

care items. The Plan (and each applicable Medical Option) does not cover, pay for or reimburse health care services or health care items that are prohibited by state or local law and which are illegally performed, prescribed or furnished in such state or locality

The prescription drug coverage and mail-order drug programs do not cover every medication. The following is a partial list of excluded drugs and medicines:

- over-the-counter items (except those required by applicable law);
- therapeutic devices or appliances (except those required by diabetics);
- drugs for infertility treatment;
- injectable drugs (except for insulin and self-administered injectable drugs that can be injected under the skin);
- drugs used for experimental, investigational or unproven purposes (as defined in the medical, expenses not covered, section) ;
- immunization agents, biological sera and the like;
- progesterone suppositories;
- general and injectable vitamins;
- drugs dispensed or prescribed in any amount exceeding supply or quantity limits or without required prior authorization;
- prescriptions which must be shipped outside the U.S. are not covered under the mail order program;
- prescriptions that are determined to be fraudulent, duplicative or that exceed dispensing protocols;
- replacement drugs resulting from a lost, stolen, broken or destroyed prescription order or refill;
- Illegal drugs and medicines that may not be prescribed within the scope of the doctor's license;
- Drugs for cosmetic purposes;
- Nutritional and diet supplements;
- Prescriptions that can be reimbursed under any workers' compensation law or government program;
- Refill orders submitted too early;
- Prescriptions ordered later than one year from the date the doctor wrote the prescription (or earlier if required by applicable law);
- Prescription drugs which are not medically necessary;
- Prescriptions purchased before coverage is in effect or after termination of coverage;
- Prescription drugs available due to service in the armed forces of any government or prescription drugs that can be reimbursed due to service in the armed forces of any government;
- Any prescription drugs used for the treatment of erectile dysfunctions, impotence, or sexual dysfunction or inadequacy, including but not limited to: sildenafil citrate, phenotolamine, apomorphine; alprostadil; or any other drug that is in similar or identical class, has a similar or identical mode for action or exhibits similar or identical outcomes; and

- Any excluded prescription drugs listed in the Cigna Health Care Benefit Summary for your medical option, posted on People Link.

Limitations on Benefits

Lifetime Maximum Benefits

Each medical option has no lifetime maximum for any covered benefit that is determined to be an essential health benefit under applicable federal law.

Separate benefit annual and lifetime maximums may apply to non-essential health benefits as set forth in this SPD.

Case Management

Covered Services and Supplies under this Plan are subject to Case Management.

Case Management determines whether the services or supplies are Covered Health Services. No benefits are payable unless Case Management determines the Covered Services and Supplies are covered under the Plan.

The Case Management program is designed to encourage an efficient system of care by identifying and addressing possible un-met covered health care needs. This may include admission counseling, inpatient care advocacy and certain discharge planning and disease management activities. The Case Management activities are not a substitute for the medical judgment of your physician. The ultimate decision as to what medical care you or your dependents receive must be made by the patient and his or her physician.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

1. You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program may refer an individual for Case Management.

2. Each case is assessed to determine whether Case Management is appropriate.

3. You or your dependent is contacted by an assigned Case Manager who explains in detail how the program works.

4. Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence).

5. The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).

6. The Case Manager also acts as a liaison between Cigna, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).

7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

Who to Contact

To contact Case Management, call Cigna at the phone number listed on your ID Card.

You can expect to receive phone calls from Cigna when certain treatments are involved.

The ultimate decisions on medical care must be made by the covered person and his or her physician. Case Management only determines if the listed service or supply is a Covered Health Service according to the Plan benefits and provisions.

Approval by Case Management does not guarantee that benefits are payable under this Plan. Benefits are based on:

- the Covered Service and Supplies actually performed or given;
- the Covered Person’s eligibility under this Plan on the date the Covered Services and Supplies are performed or given; and
- deductibles, coinsurance, maximum limits, and all other terms of this Plan.

When to Notify Case Management

For *inpatient confinement*, you must notify Case Management of the scheduled admission date at least five working days before the start of the confinement. An admission date may not have been set when the confinement was planned. You must call Case Management again as soon as the admission date is set.

Pregnancy is subject to the following notification time periods:

- Prenatal Programs – Case Management should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in the prenatal program.

- Inpatient Confinement for Delivery of Child – Case Management must be notified only if the inpatient care for the mother or child is expected to continue beyond:
    - 48 hours following a normal vaginal delivery; or
    - 96 hours following a cesarean section.

- For inpatient care (for either the mother or child) which continues beyond the 48/96 hour. For inpatient care (for either the mother or child) which continues beyond the 48/96 hour limits stated above, Case Management must be notified before the end of these time periods.

- Non-Emergency Inpatient Confinement without Delivery of Child — Confinement during pregnancy but before the admission for delivery, which is not **Emergency Care** requires notification as a scheduled confinement. Case Management must be notified prior to the scheduled admission.

For *outpatient services* which require notification, you must notify Case Management at least five working days before the service is given.

For *organ/tissue transplants*, you must notify Case Management at least seven working days before the scheduled date of any of the following or as soon as reasonably possible:

- evaluation;
- donor search;
- organ procurement/tissue harvest;
- transplant.

Case Management will then complete a review. You, your physician and the facility will be sent a letter confirming the results of the review.

Appealing a Decision

If you do not (or your Physician does not) agree with Case Management's decision, it can be appealed. You or your Physician can request Case Management to reconsider the decision by writing or telephoning within 60 days of the decision.

If you, your Physician and Case Management still cannot find an acceptable solution, this decision can be appealed a second time. Another Physician will review the facts of the case — taking into account all points of view — and make a final decision.

Case Management of Serious Illness

The Plan Administrator, in its sole discretion, has the authority to approve recommendations by Case Management for treatment, even though such treatment may not otherwise be reimbursable under the Plan, as long as Case Management confirms that the recommended treatment is:

- medically necessary;
- a covered service under the Plan; and
- deemed an effective treatment for the patient's condition.

If you choose to reject Case Management's recommendation, you will be responsible for all medical charges relating to the treatment of your serious illness that are not otherwise reimbursable.

Coordination of Benefits (COB)

If you or a member of your family is covered by another health plan, there may be some duplication of benefit coverage between the Equifax plan and the other health plan. For this purpose, "health plan" includes any group or individual health insurance plan, policy or contract, another employer's medical plan, and the medical care component of any long-term care plan or policy.

Note: When you are covered by another plan as primary, the prescription benefits will be coordinated by the medical plan options up to the normal prescription copay. You will be responsible for the normal prescription copay regardless of other group coverage.

Health Plan Rules

If you are an active employee, your Equifax coverage is always primary. If you are also covered through your spouse's or domestic partner's health plan, this health plan is considered secondary. The primary plan pays benefits first, up to that plan's limits. The secondary plan will not pay benefits until the primary plan pays a portion or denies a claim. The total benefits paid from both plans cannot be greater than the benefits under the richer plan. The following are the regular rules for health plans. Special rules are discussed below with respect to other coordination situations.

- If enrolled, the Equifax medical options are primary for employees. Any health plan covering you other than as a current employee is secondary.
- Any other health plan covering your spouse/partner or a dependent as an employee is the primary plan for that person. For example, if your spouse or domestic partner is covered by a health plan offered by his or her employer, then that plan will be primary for your spouse or domestic partner.
- If your child or domestic partner's child is covered by an Equifax medical option and your spouse's or domestic partner's health plan as a dependent, then the birthday

rule determines which is primary. Under the birthday rule, the plan of the parent whose birthday falls earliest in the calendar year is your child's primary plan. If both parents have the same birthday, the parent who has been covered longer has the primary plan. If your spouse's or domestic partner's plan does not have the birthday rule, then the father's plan is primary.

- If parents are divorced or separated and a court decree establishes financial responsibility for medical care of a child, then the health plan of the parent assigned that responsibility will be that child's primary plan. In the absence of a court decree and when not remarried, the health plan of the parent with primary physical custody will pay benefits before the health plan of the other parent. If the parent with custody has remarried and the stepparent's health plan also covers the child, the health plan of the parent with custody will pay first, the health plan of the stepparent will pay next, and the health plan of the parent without custody will pay last.

Please Note: If you have COBRA continuation coverage, then you are no longer an active employee. This means that your Equifax medical coverage will not be primary, but rather will be secondary, if you have Equifax COBRA continuation coverage and any other health coverage (including Medicare).

There are two other rules to keep in mind regarding double coverage. First, when an individual has coverage from two employers—one a current employer, the other, a previous employer—the current employer's health plan is primary. Second, when the preceding rules do not resolve which health plan is primary, the health plan covering the individual the longest is primary. When a health plan does not have a coordination of benefits provision, the rules in this provision are not applicable and the other plan's coverage is automatically considered primary.

Special Rules

Even if an Equifax medical option is your normal primary or secondary health plan, in all events any Workers' Compensation coverage, the medical or other compensation component of a personal umbrella insurance policy or contract, the medical or other compensation component of any homeowner's/renter's insurance policy or contract, and any group or individual automobile insurance policy or contract (including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, and no-fault automobile insurance coverage) will be the primary plan for accidents and injuries that are covered by, reimbursable by or for which compensation is otherwise payable by the applicable policy or contract. The Equifax medical options will then pay secondary. In addition, for employees and dependents covered by no-fault automobile insurance all medical expenses related to an automobile accident must be submitted to the automobile insurance carrier first, and the Equifax medical options will pay second. The Equifax medical options will pay covered expenses only according to the coordination of benefit rules discussed above.

How Coordination Works

When the Equifax medical options are primary, your medical option pays benefits as if it were the only plan. After your medical option pays its benefits or denies a claim, you may file a claim for any unpaid amounts with the secondary plan.

Here is how your Equifax medical option coordinates benefits when it pays secondary to any health plan, policy or contract (e.g., automobile insurance):

- Your medical option determines the benefit that would be paid if it were the only plan. This includes applying the appropriate benefit levels and all other benefit limitations.
- The amount of benefit paid by the primary plan, policy or contract (e.g., automobile insurance) is subtracted from any benefit that would be paid by your medical option. This means that when your medical option is secondary, it will only pay the difference, if any, between its usual benefit and the benefit paid by the primary plan, policy or contract.

Therefore, coverage under an Equifax medical option and another plan may not result in your receiving 100 percent reimbursement for your health care expenses.

Coordination with Medicare

Generally an individual becomes eligible for Medicare, once they satisfy one of the following criteria

- Age 65.
- Receipt of no less than 24 months of Social Security disability benefits regardless of age; or
- Diagnosis with end stage renal disease (ESRD), subject to certain exceptions.

If you become eligible for Medicare while actively employed by the Company, you will continue to be covered under your Equifax medical plan option and your Equifax medical option will be primary—that is, you will receive benefits from the Equifax medical plan option first. Further, while you are an active employee, your eligible dependents who are Medicare-eligible (whether due to reaching age 65 or being disabled) will have primary coverage under your Equifax medical plan option, and secondary coverage under Medicare.

Once you are no longer an active employee, Medicare coverage will become primary for you and your eligible dependents who are Medicare-eligible. This includes the period of time you are on COBRA continuation coverage. If you or your dependent are Medicare-eligible and are on COBRA continuation coverage, Medicare will be primary, and you should enroll in Medicare as soon as you are eligible, as a penalty applies for late enrollments in Medicare Part B. If you enroll late, Medicare can apply this penalty for as long as you are enrolled in Part B.

You must contact the Social Security office at 1-800-772-1213 to apply for Medicare Part A and Part B. It is not done through Equifax. You should also be aware that failure to enroll within the applicable Medicare enrollment period after you or your spouse/dependent become eligible, means that you may have to wait until the following year to enroll and may have to pay higher premiums (i.e., a penalty) once you do enroll in Medicare. To determine your applicable Medicare enrollment period or if you have any questions regarding Medicare, you should contact your local Social Security Office or review the Medicare and You Handbook at http://www.medicare.gov.

A Closer Look: Medicare

Medicare is a federal health insurance program for people age 65 or older, people of any age with permanent kidney failure and certain disabled people under age 65. Medicare has three parts: hospital insurance (Part A), supplementary medical insurance (Part B) and prescription drug benefits (Part D). Part A insurance helps pay for medically necessary hospital services, inpatient and outpatient hospital care, skilled nursing facilities, home health agencies and hospices. Medicare Part B insurance helps pay for physicians' services and other out-of-hospital expenses not covered by Part A. Medicare Part D provides coverage for your prescription drug costs. Note that if you are eligible for Medicare Part A & B and you are not actively employed, the Equifax medical plan will pay benefits as if you are covered for Medicare Parts A & B, even if you do not elect such coverage.

Your coverage under an Equifax medical option covering you as an active employee, or dependent or spouse of an active employee will not be affected, if you or your Medicare-eligible dependent or spouse enrolls in a Medicare prescription drug plan. However, if you drop coverage with Equifax and enroll in a Medicare prescription drug plan, you will not be able to re-enroll for active coverage in an Equifax medical option until the next annual enrollment period, or a qualifying change in status, if earlier (provided that you are otherwise still eligible to enroll). Therefore, you should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Reimbursement and Subrogation Rights of the Plan

Reimbursing the Plan

If you suffer a loss or injury caused by the actions or omissions of a third party, that third party may be responsible for paying your medical expenses. For this purpose, a "party" means any individual, entity, person or other party responsible for causing your loss or injury or responsible for making any payment to you due to your accident, injury or illness, including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, no-fault automobile insurance coverage, homeowner's/renter's insurance, personal umbrella coverage, Workers' Compensation coverage and any first-party insurance coverage. However, a party does not include any individual or supplementary insurance policy or coverage classified as an individual cancer, individual specific disease or individual hospital indemnity policy (e.g., CIGNA supplemental policies). For purposes of any applicable coordination of benefits rules, a third party shall pay primary and the plan shall pay secondary. Any amounts paid or received from or on behalf of a third party are referred to as third party proceeds.

For example, if you are injured in a car accident, the person who caused the accident (and the person's insurer) are the third parties and may be responsible for paying for your injury-related expenses. Your insurance company may also be a third party. You will be required to provide the plan or its agents information concerning any claim or lawsuit you may have against a third party for injury caused by that party. You must also provide the plan or its agents any documents or information relevant to the protection of the plan's rights of reimbursement.

You agree to cooperate fully with the plan's efforts to recover benefits paid. If you do not cooperate as required or requested, the claims administrator may terminate your injury-related benefits from and after a certain date even if your injury-related benefits were approved before that date. It is your duty to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. You agree to provide the plan or its representatives notice of any third party proceeds or other recovery you obtain prior to receipt of such funds or within 5 days if no notice was given prior to receipt. Further, you agree to provide notice prior to any disbursement of third party proceeds or any other recovery of funds. You shall provide all information requested by the plan, the Claims Administrator or its representative including, without limitation, completing and submitting any applications or other forms or statements as the plan may reasonably request and all documents related to or filed in personal injury litigation. You shall do nothing to prejudice the plan's subrogation or recovery interest or prejudice the plan's ability to enforce the terms of any plan provision. This includes, without limitation, refraining from making any settlement or recovery that attempts to reduce or exclude the cost of any or all benefits provided by the plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the plan's reimbursement interest.

Current and/or future plan benefits may be reduced and/or offset (in whole or in part) in the sole discretion of the plan at any time to recover any third party proceeds. The reduction and/or offset of current and/or future plan benefits (in whole or in part), shall be accomplished by the plan as a right of administrative set off without the need to initiate any legal action. The plan may reduce and/or offset plan benefits from and after a designated date, even if plan benefits were not reduced and/or offset prior to a designated date.

The plan may initiate legal action against you (or anyone else holding the third party proceeds, such as a legal representative or trust) to collect the third party proceeds and may take any other actions (even if not set forth in this section) to protect the plan's right of reimbursement.

If you receive any type of payment, reimbursement or legal recovery from the third party or an insurer (referred to as third party proceeds), you are obligated to reimburse the plan for:

- Any benefits or expenses that the plan paid for the accident/injury/illness;

- Any projected benefits or expenses the plan will pay in the future with respect to the accident/injury/illness; plus
- Any related legal and collection costs the plan incurred.

Your obligation to reimburse the plan exists for any legal recovery that relates to an accident, injury or illness for which the plan paid benefits (including any amounts used to pay your legal fees), even if you recover less than initially claimed (or less than your full loss) and even if the legal recovery is designated as not for medical expenses. The plan is entitled to recover from any and all settlement or judgements, even those designated as pain and suffering, non-economic damages and/or general damages only. The plan's reimbursement claim shall not be reduced due to your own negligence. Further, the plan's reimbursement shall not be reduced by any legal or attorney costs or fees you may incur in obtaining the third party proceeds, unless and only to the extent such reduction is allowed by a written agreement.

In addition, the right of full and unreduced reimbursement shall also apply even if the rights of the plan are separated and treated as not resolved in the judgment, settlement, verdict or insurance proceeds (but in this case, the plan's rights shall be assigned to you to the extent reimbursement is actually received out of the recovery). The plan's right to receive any payment, reimbursement or recovery discussed in this section supersedes and has priority over your right to receive any payment, reimbursement and recovery and supersedes any applicable state laws that otherwise may directly or indirectly conflict with the provisions of this section.

In order to recover any reimbursement, payment, overpayment or excess payment to which the plan has a right of reimbursement as provided above, you, as a condition of receiving benefits under the plan, grant to the plan the following rights:

- A first priority equitable lien against the third party proceeds (i.e., any settlement, verdict, insurance proceeds or other amounts) received by you or on your behalf from or on behalf of any third party that may be responsible for an illness, injury or condition for which the plan incurred expenses or paid benefits. The amount of the lien is equal to the amount of prior and future benefits paid by the plan.
- The right to impose a constructive trust on the third party proceeds (i.e., any settlement, verdict, insurance or other amounts) awarded, transferred or paid by or on behalf of a third party to you and any other person or entity holding the proceeds, including a legal representative or trust.
- The right of administrative set off against current and/or future plan benefits without the need to bring any legal action or proceeding.
- The right to bring any legal action or proceeding, including, without limitation, to enforce the above rights in any court of competent jurisdiction as the plan may elect, and upon receiving benefits under the plan, you hereby submit to each jurisdiction regardless of your current or future residence.

- An assignment to the plan of any benefits or claims or rights of recovery you have under any insurance policy or other coverage to the full extent of the plan's reimbursement claims.

Third party proceeds held directly or indirectly by you are intangible assets of the plan and are held by you in a constructive trust for the benefit of the plan. Any participant or dependent who directly or indirectly holds or exercises any control over third party proceeds is an ERISA fiduciary with respect to the third party proceeds and must hold the third party proceeds for the exclusive benefit of the plan. A legal representative is an ERISA fiduciary solely with respect to his or her direct or indirect control of third party proceeds and not with respect to his or her legal representation of you. No disbursement of third party proceeds or other recovery funds from any insurance coverage or other source shall be made until the plan's right of reimbursement interest is fully satisfied.

The plan's right of reimbursement shall apply without regard to any equitable defenses that a third party, participant and/or dependent asserts or may be entitled to assert, including any defense of unjust enrichment. ERISA preempts any state or local law, or any regulation issued thereunder, which prohibits or attempts to limit the plan's right of reimbursement. Neither the make whole doctrine nor the common fund doctrine apply to the plan.

For purposes of this section, "you" and "your" includes your spouse/partner/dependents, your agent and any agent of the foregoing, your attorney and any attorney of the foregoing and your estate and any estate of the forgoing.

Right of Subrogation

When another party is legally responsible or agrees to compensate you for an accident, illness or injury for which the plan has paid benefits, the plan has the same rights ("right of subrogation") that you have against the party. For this purpose, a "party" means any individual, entity, person or other party responsible for causing your loss or injury or responsible for making any payment to you due to your injury, illness or condition, including uninsured motorist coverage, underinsured motorist coverage, traditional fault-based automobile insurance coverage, no-fault automobile insurance coverage, homeowner's/renter's insurance, personal umbrella coverage, Workers' Compensation coverage and any first-party insurance coverage. However, a party does not include any individual or supplementary insurance policy or coverage classified as an individual cancer, individual specific disease or individual hospital indemnity policy (e.g., CIGNA supplemental policies).

The plan's rights of subrogation shall supersede any applicable state laws that otherwise may directly or indirectly conflict with the plan's right of subrogation.

In addition, the plan expressly rejects and overrides any default rule that the plan does not have a right of subrogation until you have been fully compensated. If you enter into litigation or settlement with another party, the plan's right of subrogation will still apply.

The provisions set forth above under “Reimbursing the Plan” shall fully apply under this section as well.

Recovery of Excess Payments and Overpayments

If a benefit payment is made under the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right:

- To require the return of the overpayment from any person, insurance company or other entity or organization to whom the overpayment was made; and/or
- Reduce and/or offset current and/or future plan benefits (including those of another person in the family) at any time to recover the overpayment.

The reduction and/or offset noted above shall be accomplished by the plan as a right of administrative set off without the need to initiate any legal action. Such reduction and/or offset may occur from and after a designated date, even if plan benefits were not reduced and/or offset prior to a designated date.

An “overpayment” includes – (1) any payment of plan benefits received by or on behalf of yourself or a dependent, which you or a dependent is not entitled to under the terms of the plan, (2) any payment of plan benefits received by or on behalf of yourself or a dependent, which are in excess of the amount necessary to satisfy the requirements of this plan, and (3) any additional payment of plan benefits to or on behalf of a healthcare provider, where the plan has previously paid plan benefits to or on behalf of yourself or dependent and you or the dependent has failed to remit all or a portion of the previous payment(s) to the provider. Overpayments also include any legal costs, attorneys’ fees and court costs incurred as a result of or relating to the overpayment.

This right does not affect any other right of recovery the plan may have with respect to overpayments.

In addition to the above, the plan may also reduce future payments to the provider by the amount of the overpayment. These future payments may involve this plan or other health plans that are administered by the carrier. Under this process, the carrier reduces future payments to providers by the amount of the overpayment they received, and then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this plan are subject to this same process when the carrier recovers overpayments for other plans administered by the carrier.

Special Situations

If You Work Past Age 65

If you continue working full time as an Eligible Employee after age 65, your Equifax coverage will remain primary. You will have the same coverage as active employees under age 65.

If your spouse is 65 or older, the Plan will provide primary coverage for him or her while you are actively employed.

COBRA continuation coverage is not considered active employment, and the plan will pay secondary.

If You Take a Leave of Absence

If you take an approved leave of absence, coverage will continue as long as you pay your premiums when they are due (see the Overview section for details). However, coverage will terminate on the later of six months from the beginning of your leave or the last day of the calendar year in which your leave began.

Special rules apply if you are on FMLA leave or military leave. If you think these special rules apply to you or if you have any questions, create an “Ask HR” ticket from People Link for assistance.

If You Become Disabled

If you become eligible for Short-Term Disability benefits, medical coverage continues under the Medical Plan as set forth in this Summary Plan Description.

If you become eligible for Long-Term Disability benefits, your medical coverage is automatically transferred to the Equifax Inc. Retiree Health Care Program. As part of the transfer of your medical coverage to the retiree plan, you will be transferred to a health reimbursement arrangement (“HRA”) where Equifax will provide you with HRA dollars to purchase individual coverage for yourself and your family. Once you become eligible for the HRA, Equifax will inform you of your HRA dollar credit. The HRA coverage is only offered for up to 36 months following the effective date that your Long-Term Disability benefits commence. After the 36-month period ends, your HRA coverage terminates.

As an alternative to the HRA coverage, you will also be offered the opportunity to elect COBRA continuation coverage for your active medical plan when you become eligible for LTD benefits. Equifax will not pay for the COBRA continuation coverage and you will be responsible for paying the entire premiums. COBRA continuation coverage ends after 18 months (unless you are eligible for a temporary extension). Once your COBRA continua-

tion coverage ends you will have the opportunity to enroll in the HRA coverage for the remainder of the 36-month period. After the 36-month period ends, your HRA coverage terminates.

Medical Coverage for Dependents If You Die

If you die while you are an active employee, extended coverage may be available to your eligible spouse/dependents.

If you are not enrolled in retiree medical coverage on the date of your death, your surviving spouse/partner and dependents may continue coverage through COBRA with a 50% subsidy on the COBRA rates for up to 1 year after your death, as long as they pay the required premiums. After one year, they may continue COBRA coverage for up to two additional years at the full premium rate. The beneficiary of your HSA may use the HSA for qualifying claims.

If you are eligible for retiree medical coverage, but you are not enrolled in retiree medical on the date of your death, your spouse and dependents will not be able to elect retiree medical coverage. You and your eligible spouse and dependents must be enrolled in retiree medical coverage at the time of your death for your eligible spouse and dependents to continue retiree medical coverage after your death. See the Pre-65 and Post-65 Retiree Medical Summary Plan Descriptions for retiree medical eligibility requirements and related information. A domestic partner and his/her dependent children are not eligible for retiree medical coverage.

Except as otherwise provided, the extended coverage set forth above is subject to the regular terms and conditions of coverage that otherwise apply to employees. All extended coverage in case of death is subject to the Company's right to terminate completely or to change in any way the coverage provided to current and former employees and their spouse/partner/dependents.

Filing a Claim

If you use a Cigna network provider, there is no need to file a claim form. Your provider will submit the claim for you. If you receive care out-of-network, you or your provider will have to file a claim for reimbursement. Claim forms can be obtained on www.mycigna.com.

In-Network, Participating Provider Claims

All Cigna participating providers will have 90 days after the date of service to submit their claims. Claims that are received more than 90 days after the date of service will be denied, unless regulatory requirements dictate other timeframes or there are certain extenuating circumstances that caused the late filing. You will not be held responsible for in-network claims not filed timely by your provider.

Non-Participating (Out-of-Network) Claims

Providers and employees will have 180 days after the date of service to submit non-participating (out-of-network) claims. Claims that are over 180 days after the date of service will be denied, unless regulatory requirements dictate other timeframes or there are certain extenuating circumstances that caused the late filing. You can be balance billed for any denied claims, just as you are currently for out-of-network claims. In many situations, an out-of-network provider will file your claim for you. However, it is always your responsibility to make certain an out-of-network provider timely files your claims.

> **A Closer Look: Claims Filing**
>
> *Remember:*
>
> - All bills must be itemized, showing your name and Social Security number, the company's name and Cigna group number (3333787), the patient's name, the diagnosis and the date and nature of the service or supplies provided.
> - If you have other coverage and your other plan is primary, you must submit a copy of their statement showing that coverage (see "**Coordination of Benefits**").
> - If your provider is filing your claim, make sure he or she knows the deadlines listed above. If the claim is denied for failure to file before the deadline, your provider may seek to receive payment directly from you (if the provider is out-of-network).

You will receive an Explanation of Benefits (EOB) for each claim filed, describing the expenses submitted, any exclusions or deductibles and the benefits paid, if any. If you disagree with a claims determination, you may appeal it using the claims procedures listed in the Administrative Information section located on People Link.

For more information about claims, visit Cigna's web site at www.mycigna.com.

For information about your rights under the Employee Retirement Income Security Act (**ERISA**) and other important legal information, see the Administrative Information section located on People Link.

Rescission of Coverage

Rescission of coverage is a cancellation or discontinuation of coverage that has retroactive effect. However, a cancellation or discontinuation of coverage is not a rescission if it –

- Is one that you voluntarily request with a retroactive effective date;
- Is only effective prospectively;
- Is attributable to a failure to timely pay required premiums or contributions;

- Results from a participant's termination of employment; or
- Results from the dependent's failing to satisfy the applicable eligibility requirements to be a dependent.

Under the rescission rules, the plan will not rescind your medical and prescription drug coverage for a participant or covered dependent unless the participant or covered dependent performs an act, practice, or omission that constitutes fraud (as defined by the plan) or intentionally misrepresents a material fact with respect to the medical or prescription drug coverage or fails to pay the premium. The plan shall provide the participant or covered dependent with at least 30 days' advance written notice of any rescission. All rescissions are subject to the claims and appeals procedures applicable to the medical or prescription drug coverage, as set forth in the Administrative Information section.

The above rescission rules apply only to medical and prescription drug coverage. The rescission rules do not apply to any other health and welfare benefit.

Cooperation

In order to participate in Equifax medical and prescription drug coverage, you and your enrolled spouse/partner/dependents are required to cooperate with the plan and claims administrators and provide the plan and claims administrators with information that is needed to administer your benefits. This includes providing the plan and claims administrators with your and your spouse/partner/dependent's correct Social Security numbers, correct legal names and correct birthdates. You must also respond to reasonable requests of the plan and claims administrators for additional information, and assist the plan and claims administrators in correcting any claims paid in error or for the wrong amount. Failure to cooperate with the plan and claims administrators as set forth above may result in the termination or suspension of your and your spouse/partner/dependent's medical and prescription drug coverage.

Glossary

The definitions set forth below apply regardless of whether the term or phrase is capitalized or bolded in this SPD.

Chiropractic Care

An alternative medicine therapy in which the spine and joints are adjusted to treat pain and improve general health.

Coordination of Benefits

A feature of many health plans that prevents the health plan from paying more than the plan benefit if you or a covered family member is covered by more than one plan, including Medicare.

Doctor

A medical practitioner of a healing art (also known as “physician”) recognized by applicable state law, who:

- Is practicing within the scope of his or her license;
- Is certified or credentialed by the appropriate medical or professional board for practitioners who perform the type of treatment or service such practitioner is providing for your sickness or injury; and
- Possesses the necessary training and qualifications, according to generally accepted medical standards, to evaluate and treat your condition.

The term “doctor” does not include you, an employee of Equifax, anyone related to you by blood or marriage, or anyone living in your household. Sometimes “Doctor” is referred to as a “physician” in this summary.

EOB

Explanation of Benefits. This is a statement explaining how benefits were determined under a plan (e.g. medical, dental or vision) and to whom they were paid. Claims not payable under the Plan are explained.

Home Health Care Agency

An agency or organization which provides a program of home health care and which meets one of the following three requirements:

- Is approved under Medicare;
- Is established and operated in accordance with applicable licensing and other laws; or
- The agency or organization meets all of the following conditions:
  - Primarily provides a home health care delivery system to bring supportive services to the home;
  - Has a full-time administrator;
  - Maintains written records of service provided to the patient;
  - Has a staff which includes at least one R.N. or has nursing care provided by an R.N.; and
  - Its employees are bonded and it maintains malpractice insurance.

Hospice

An agency providing counseling and incidental medical services for a terminally ill individual. Room and board may be provided. The agency must meet one of the following three tests:

- Be approved by Medicare as a Hospice;
- Be licensed in accordance with any applicable state laws; or
- The agency meets the following criteria:
  - It provides 24 hour-a-day, seven day-a-week service;
  - It is under the direct supervision of a qualified physician;
  - It is has a nurse coordinator who is an R.N. with four years of full-time clinical experience, two of which must have involved caring for terminally ill patients;
  - Its main purpose is to provide hospice services;
  - It has a full-time administrator;
  - It maintains written records of services given to the patient; and
  - It maintains malpractice insurance coverage.

Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense, and which fully meets one of the following three tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations;
- It is approved by Medicare as a hospital; or
- The institution meets all of the following criteria:
  - It maintains on-site diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of qualified physicians;
  - It continuously provides on-site 24-hour-a-day nursing service by or under the supervision of RNs; and
  - It is operated continuously with organized facilities for operative surgery on site.

Medically Necessary or Medical Necessity

A service or supply furnished by a particular provider is necessary if Cigna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be medically necessary, the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and

- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is medically necessary under the circumstances, Cigna will take into consideration:

- Information provided on the affected person's health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to Cigna's attention.

In no event will the following services or supplies be considered medically necessary:

- Those that do not require the technical skills of a medical, a mental health or a dental professional; or
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Participating or Network Provider

A physician, dentist or eye care professional (as applicable) who has agreed to participate in a health care network sponsored by Cigna.

Skilled Nursing Facility

A skilled nursing facility is an institution that provides skilled nursing and physical rehabilitation services to patients recovering from an injury or illness. If the facility is approved by Medicare as a skilled nursing facility, then it is covered by this Plan. If it is not approved by Medicare the facility may be covered if it meets all of the following tests:

- Is operated under the applicable licensing and other laws;
- Is under the supervision of a licensed physician or registered graduate nurse (R.N.) who is devoting full time to supervision;

- Is regularly engaged in providing room and board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or sickness;
- Maintains a daily medical record of each patient who is under the care of a licensed physician;
- Is authorized to administer medication to patients on the order of a licensed physician; and
- Is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home or a home for persons with narcotic dependencies or mental illnesses.

A skilled nursing facility which is part of a hospital will be considered a skilled nursing facility for the purposes of this Plan.

Your Rights Under ERISA

For information about your rights under the Employee Retirement Income Security Act (**ERISA**) and other important legal information, see the Administrative Information section located on People Link.

Equifax reserves the right at any time, without advance notice and without contingency upon financial necessity, to change the Plan in any respect, including the eligibility requirements and contribution rates, or to modify, reduce or terminate the entire Plan or any part thereof. No changes to the Plan will affect benefits that have already become payable, as of the effective date of such changes, for already received services and supplies.

All services, plans and benefits are subject to and governed by the terms (including exclusions and limitations) of the agreement between Cigna and Equifax. The information herein is subject to change without notice.