

CWP dba Mister Car Wash

ANNUAL COMPLIANCE RIDER

EFFECTIVE DATE: July 1, 2016

ACAZD16
3337921

This document printed in May, 2016 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

ANNUAL COMPLIANCE RIDER

No. ACAZD16

Policyholder: CWP dba Mister Car Wash

Rider Eligibility: Each Employee

Policy No. or Nos. 3337921-DPOH, DPOL

EFFECTIVE DATE: July 1, 2016

You will become insured on the date you become eligible, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status. If you are not insured for the benefits described in your certificate on that date, the effective date of this annual compliance rider will be the date you become insured.

This Annual Compliance Rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified above.

This Annual Compliance Rider replaces any other Annual Compliance Rider issued to you on a prior date.

The provisions set forth in this Annual Compliance Rider comply with legislative requirements of the State of Arizona regarding group insurance plans covering insureds. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

READ THE FOLLOWING

NOTE: The provisions identified in this rider are specifically applicable ONLY for:

- Benefit plans which have been made available by your Employer to you and/or your Dependents;
- Benefit plans for which you and/or your Dependents are eligible;
- Benefit plans which you have elected for you and/or your Dependents;
- Benefit plans which are currently effective for you and/or your Dependents.


Anna Krishtul, Corporate Secretary

The following replaces the section entitled **When You Have a Complaint Or An Appeal** shown in your certificate and applies to your **dental** coverage.

When You Have a Complaint Or An Appeal

For the purposes of this section, any reference to “you,” “your” or “Member” also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems. The following describes the process by which Members may obtain information and submit concerns regarding service, benefits, and coverage. For more information, see the Appeals Process Information Packet (“Appeal Packet”). We will provide you a copy of the Appeal Packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call Customer Services Toll-Free Number: 1-800-Cigna24 (1-800-244-6224).

Start with Customer Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the following:

Customer Service Toll-Free Number that appears on your explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Cigna has a two step appeals procedure for coverage decisions. To initiate an appeal, you can submit a request for an appeal by calling or writing us within two years of receipt of a denial notice. You can call us at the Customer Service Toll-Free Number 1-800-Cigna24 (1-800-244-6224) that appears on the explanation of benefits or claim form, or you can write to us at the following address:

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

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your explanation of benefits or claim form.

Level One Appeal

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

Within five business days after receiving your request for review, Cigna will mail you and your Dentist or treating provider a notice indicating that your request was received, and a copy of the Appeal Packet (sent to Dentist or treating provider upon request). For level one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a coverage determination.

You may request that the appeal process be expedited if, your Dentist or treating provider certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. When an appeal is expedited, we will respond orally and in writing with a decision within one business day.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal. Please send your review request relating to denial of a requested service that has not already been provided within 365 days of the last denial. Your review requests relating to payment of a service already provided should be sent within two years of the last denial. To help us make a decision on your appeal, you or your provider should also send us any more information

(that you haven't already sent us) to show why we should authorize the requested service or pay the claim.

If the appeal involves a coverage decision based on issues of medical necessity or clinical appropriateness, a review will be conducted by a Dentist or Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was not involved in any previous decision related to your appeal, and not a subordinate of previous decision makers. Provide all relevant documentation with your second-level appeal request.

For level two appeals we will acknowledge in writing that we have received your request within five business days after receiving your request. For coverage determinations, the Cigna review will be completed within 15 calendar days. For postservice claims, Cigna review and written notification of the decision will be completed within 30 calendar days. If more time or information is needed to make the preservice or concurrent care determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

You may request that the appeal process be expedited if, your Dentist or treating provider certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services, or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. When an appeal is expedited, we will respond orally with a decision within 3 business days, followed up in writing.

At any time during the appeal process Cigna has the option to send your appeal directly to External Independent Review without making a decision during the appeal process.

External Independent Review

Eligibility

Under Arizona law, a Member may seek a Standard External Independent Review only after seeking any available level one appeal and level two appeal. Your request for a Standard External Independent Review should be submitted in writing.

Deadlines Applicable to the Standard External Independent Review Process

After receiving written notice from Cigna that your level two appeal has been denied, you have 4 months to submit a written request to Cigna for External Independent Review. Your request must include any material justification or documentation to support your request for the service or payment of a claim.

Medical Necessity Issues

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not Medically Necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization (“IRO”), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review. If your appeal for External Independent Review involves an issue of medical necessity:

- Within five business days of receipt of your request for External Independent Review, Cigna will:
 - mail a written notice to you, your Dentist or treating provider, and the Director of the Arizona Department of Insurance (“Director of Insurance”) of your request for External Independent Review, and
 - send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.
- Within five days of receiving our information, the Insurance Director must send all submitted information to an external independent review organization (the “IRO”).
- Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.
- Within five business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider. If the IRO decides that Cigna should provide the service or pay the claim, Cigna must then authorize the service or pay the claim. If the IRO agrees with Cigna's decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Coverage Issues

These are cases where we have denied coverage because we believe the requested service is not covered under your certificate of coverage. For contract coverage cases, the Arizona Insurance Department is the independent reviewer. If your appeal for External Independent Review involves an issue of service of benefits coverage or a denied claim:

- Within five business days of receipt of your request for External Independent Review, Cigna will:
 - mail a written notice to you, your Dentist or treating provider, and the Director of Insurance of your request for External Independent Review, and
 - send the Director of Insurance: your request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.
- Within 15 business days of the Director's receipt of your request for External Independent Review from Cigna, the Director of Insurance will:
 - determine whether the service or claim is covered, and
 - mail the decision to Cigna. If the Director decides that we should provide the service or pay the claim, we must do so.
- If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have five business days after receiving the IRO's decision to send the decision to us, you, and your treating provider.
- Cigna will provide any covered service or pay any covered claim determined to be Medically Necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director of Insurance regardless of whether Cigna elects to seek judicial review of the decision made through the External Independent Review Process.
- If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If Cigna disagrees with the Insurance Director's final decision, Cigna may also request a hearing before the OAH. A hearing must be requested within 30 calendar days of receiving the Insurance Director's decision.

Expedited External Independent Review Process

You may request an external review only after you have appealed through levels 1 and 2. You have only 5 business days after you receive our level 2 decision to send us your

written request for Expedited External Independent Review. Neither you nor your treating provider is responsible for the cost of any external independent review.

For medical necessity cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not Medically Necessary, we will acknowledge your request within 1 business day of receiving your request. Within 2 business days of receiving our information, the Insurance Director must send all the submitted information to an external independent review organization (the "IRO"). Within 72 hours of receiving the information the IRO must make a decision and send the decision to the Insurance Director. Within 1 business day of receiving the IRO's decision, the Insurance Director will notify you of its decision. If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

For contract coverage cases where we have denied coverage because we believe the requested service is not covered under your insurance policy, within 1 business day of receiving your request we will acknowledge your request in writing. Within 2 business days of receiving this information, the Insurance Director will determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider. If the Insurance Director cannot issue a decision, your case will be forwarded to an IRO. The IRO will have 5 business days to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO's decision to send the decision to us, you, and your treating provider. If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). A hearing must be requested within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from the expedited external review decision.

Under Arizona law, if you intend to file suit regarding a denial of benefit claim or services you believe are Medically Necessary, you are required to provide written notice to Cigna at least 30 days before filing the suit stating your intention to file suit and the basis of your suit. You must include in your notice the following:

- Member Name
- Member Identification Number
- Member Date of Birth
- Basis of Suit (reasons, facts, date(s) of treatment or request)



Notice will be considered provided by you on the date received by Cigna. The notice of intent to file suit must be sent to Cigna via Certified Mail Return Receipt Request to the following address:

Attention: HealthCare Litigation Unit B6LPA
Notice of Intent to File Suit
Cigna Health and Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written documents required to be mailed during the process is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

Complaints to the Arizona Department of Insurance

The Director of the Arizona Department of Insurance is required by law to require any Member who files a complaint with the Arizona Department of Insurance relating to an adverse decision to first pursue the review process established by the Arizona Legislature and Cigna as described above.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal decision will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

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

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action.

HC-APL117

09-13

V2 AC

Covered Dental Expense

The following Covered Expenses text for "Class IV Services – Orthodontics" in your dental certificate is replaced as follows:

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

Continued active treatment after the first month.

Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

Periodic observation of patient dentition to determine when orthodontic treatment should begin, at intervals established by the dentist, up to four times per calendar year.

HC-DEN6

04-10

V3 AC

Definitions

The following replaces the definition of “Dentist” shown in the **Definitions** section of your dental certificate:

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a provider operating within the scope of his license when he performs any of the Dental Services described in the policy.

HC-DFS125

04-10
V3 AC

Definitions

The following replaces the definition of “Maximum Reimbursable Charge” shown in the **Definitions** section of your dental certificate:

Maximum Reimbursable Charge - Dental

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 policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS752

07-14
V5 AC

The following Federal Requirements replace any such provisions shown in your Certificate.

Federal Requirements

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

HC-FED1

10-10 AC

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the criteria shown in the following Sections B through H.

B. Change of Status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer’s network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid Eligibility/Entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

G. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in Qualified Health Plan (QHP)

The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

HC-FED70

12-14
AC1

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67

09-14
AC

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

HC-FED54

12-13
AC1

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

The following paragraphs regarding the "Trade Act of 2002" are hereby rendered NULL and VOID:

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment

assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under “Termination of COBRA Continuation” above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

The following paragraph under “Enforce Your Rights” section found under the **ERISA Required Information** provision in your certificate is being amended to read as follows:

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

HC-FED72

05-15
AC

HC-FED66

07-14
AC

ERISA Required Information

The following bullet under “Continue Group Health Plan Coverage” section found under the **ERISA Required Information** provision in your certificate is being amended to read as follows:

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

The following bullet under the “Continue Group Health Plan Coverage” section found under the ERISA Required Information provision of your dental certificate is hereby removed:

- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you