University of New England

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2024

ETALLM24A
3345889

This document printed in February, 2024 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

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

CERTIFICATE RIDER

Policyholder: University of New England
Rider Eligibility: Each Employee as noted within this certificate rider
Policy No. or Nos.: 3345889
Effective Date: January 1, 2024

This rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified above. This rider replaces any other issued to you previously.

IMPORTANT INFORMATION

For Residents of States other than the State of Maine:

State-specific riders contain provisions that may add to or change your certificate provisions.

The provisions identified in your state-specific rider, attached, are ONLY applicable to Employees residing in that state. The state for which the rider is applicable is identified at the beginning of each state specific rider in the "Rider Eligibility" section.

Additionally, the provisions identified in each state-specific rider only apply to:

(a) Benefit plans made available to you and/or your Dependents by your Employer;
(b) Benefit plans for which you and/or your Dependents are eligible;
(c) Benefit plans which you have elected for you and/or your Dependents;
(d) Benefit plans which are currently effective for you and/or your Dependents.

Please refer to the Table of Contents for the state-specific rider that is applicable for your residence state.

Geneva Cambell Brown, Corporate Secretary

HC-ETRDRV1

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

CERTIFICATE RIDER – California Residents

Rider Eligibility: Each Employee who is located in California

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of California for group insurance plans covering insureds located in California. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETCARDR

Covered Expenses

- charges for the screening and diagnosis of prostate cancer, including, but not limited to, Medically Necessary prostate-specific antigen (PSA) testing and digital rectal examinations.
- charges made for services related to the diagnosis, treatment, and management of osteoporosis. Covered services include, but are not limited to, all FDA approved technologies, including bone mass measurement technologies as deemed Medically Necessary.
- charges made for a drug that has been prescribed for purposes other than those approved by the FDA will be covered if:
  - the drug is otherwise approved by the FDA;
  - the drug is used to treat a life-threatening condition or, a chronic and seriously debilitating condition and the drug is Medically Necessary to treat that condition;
  - the drug has been recognized for the treatment prescribed by any of the following: the American Hospital Formulary Service Drug Information, one of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology; The National Comprehensive Cancer Network Drug and Biologics compendium; The Thomson Micromedix Drug Dex ; or two articles from major peer reviewed medical journals that present data supporting the proposed use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

HC-COV992 01-20
ET1

Clinical Trials

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate; or
- the individual provides medical and scientific information establishing that the individual's participation in the qualified trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered.

The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that meets **any** of the following criteria:

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH).
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Health Care Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).
  - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
- any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:
  - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and

- the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The plan does not cover any of the following services associated with a clinical trial:

- services that are not considered routine patient care costs and services, including the following:
  - the investigational drug, device, item, or service that is provided solely to satisfy data collection and analysis needs.
  - an item or service that is not used in the direct clinical management of the individual.
  - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- an item or service provided by the research sponsors free of charge for any person enrolled in the trial.
- travel and transportation expenses, unless otherwise covered under the plan, including but not limited to the following:
  - fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train.
  - mileage reimbursement for driving a personal vehicle.
  - lodging.
  - meals.
- routine patient costs obtained out-of-network when Out-of-Network benefits do not exist under the plan.

Examples of routine patient care costs and services include:

- radiological services.
- laboratory services.
- intravenous therapy.
- anesthesia services.
- Physician services.
- office services.
- Hospital services.
- Room and Board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

Clinical trials conducted by Out-of-Network providers will be covered only when the following conditions are met:

- In-Network providers are not participating in the clinical trial; or
- The clinical trial is conducted outside the individual's state of residence.

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - the subject of an ongoing phase I, II, or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed, and is recognized as safe and effective for the treatment of cancer in any of the standard reference compendia: (A) The American Hospital Formulary Service's

Drug Information, (B) One of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i). The Elsevier Gold Standard's Clinical Pharmacology; (ii) The National Comprehensive Cancer Network Drug and Biologics compendium; (iii) The Thomson Micromedix DrugDex, (C) two articles from major peer-reviewed medical journals that that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.

HC-EXC414 01-20
V1-ET1

Definitions

Dependent

Dependents includes:

- your Domestic Partner.

If your Domestic Partner has a child, that child will also be included as a Dependent.

HC-DFS1023 10-16
ET1

Definitions

Domestic Partner

A Domestic Partner is defined as your Domestic Partner who has registered the domestic partnership by filing a Declaration of Domestic Partnership with the California Secretary of state pursuant to Section 298 of the Family Code or an equivalent document issued by a local agency of California, another state, or a local agency of another state under which the partnership was created.

HC-DFS1024 10-16
ET

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

CERTIFICATE RIDER – Colorado Residents

Rider Eligibility: Each Employee who is located in Colorado

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Colorado group insurance plans covering insureds located in Colorado. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETCORDR

Eligibility - Effective Date

Exception for Children

Any Dependent child who was previously covered under Colorado's state program for children, the Children's Basic Health Plan, will not be considered a Late Entrant for Dependent Insurance if enrollment is requested within 90 days of the Dependent child's disenrollment or loss of eligibility under the program.

HC-ELG233 01-19
ET

The Schedule

The medical Schedule is amended to indicate the following:

Preventive Care (according to USPSTF recommendations)

- Childhood Immunizations and physical examinations through age 12

For plans which comply with Health Care Reform, the above provisions are covered at "No charge".

For plans which do not comply with Health Care Reform including In-Network benefits, the above provisions are payable at "No charge" after any office visit copay In-

Network. Out-of-Network benefits are payable at "No charge".

HPV (Human Papillomavirus) Vaccine

- Any deductibles, coinsurance or maximums do not apply to charges for HPV (Human Papillomavirus) Vaccines. Charges for HPV Vaccines are payable at 100%.

Colorectal Cancer Screening

Any deductibles, coinsurance or maximums applicable to Colorectal Cancer Screenings do not apply. Charges for "routine" preventive Colorectal Cancer Screenings are payable at "No charge". For plans which do not comply with Health Care Reform including In-Network benefits, they are payable at "No charge" after any office visit copay In-Network. Out-of-Network benefits are payable at "No charge".

SCHEDCO-ET1

The Schedule

The medical Schedule is amended to indicate the following:

Early Intervention Services

- Any deductibles, coinsurance or maximums do not apply to charges for Early Intervention Services. Charges for children from birth to age 3 are payable at 100% with a contract or calendar year maximum of 45 visits.

SCHEDCO-ET5

Covered Expenses

- charges made for the full cost of the three-dose series of cervical cancer vaccines for all females for whom a vaccination is recommended by the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services. The recommended age for vaccines is females 11 through 12 years of age. The vaccine may be administered to females as young as 9 years. Catch-up vaccination is recommended for females age 13 through 26 years who have not been previously vaccinated.
- charges by a Hospital for a mother and newborn for inpatient care for 48 hours following a vaginal delivery and 96 hours of care following a cesarean section. If the 48 or 96 hours falls after 8:00 p.m., then coverage will be continued until 8:00 a.m. the following morning. No authorization of care will be required for these time frames. For longer stays, guidelines prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists will be used. A shorter length of stay is acceptable if the decision for early discharge is made by the mother and the Physician.
- charges for hearing aids for a Dependent child up to age 18, who has a hearing loss that has been verified by both a licensed Physician and a licensed audiologist, provided the hearing aids are medically appropriate to meet the needs of the child according to accepted professional standards. Benefits are payable for: the purchase of initial hearing aids, and replacement hearing aids not more frequently than every 3 years; a new hearing aid when alterations to an existing hearing aid cannot adequately meet the needs of the child; services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided in accordance with acceptable professional standards. Benefits payable under this part will not be used to reduce any durable medical equipment maximum provided by this plan.

  A hearing aid is defined as amplification technology that optimizes audibility and listening skills in the environments commonly experienced by the patient, including a wearable instrument or device designed to aid or compensate for impaired human hearing. A hearing aid shall include any part or ear molds.
- charges made for or in connection with management of pain for which a cause or cure cannot be found through reasonable efforts made by a Physician or Specialist.

HC-COV1211 01-22

V1 ET

The Schedule

The pharmacy Schedule is amended to indicate the following:

Oral Chemotherapy Medication

Prescription oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered at Participating Pharmacies at 100% after deductible, if applicable, and at Non-Participating Pharmacies, the same as the out of network medical cost share for injectable/IV chemotherapy.

SCHEDPHARM-ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review

Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of cancer in authoritative reference compendia as identified by the secretary of the U.S. Department of Health and Human Services.

HC-EXC475 01-22
ET

Expenses For Which A Third Party May Be Responsible

NOTE: *The plan may only place a lien on any recovery by the Participant that is in an amount in excess of the Participant's full compensation for all damages arising out of the claim.*

HC-SUB136 01-21
ET

Definitions

Dependent

Dependents include:

- your lawful spouse or your partner in a Civil Union;

HC-DFS1667 01-22
ET

Emergency Service Provider

The term Emergency Service Provider means a local government, or an authority formed by two or more local governments, that provide fire-fighting and fire prevention services, emergency medical services, ambulance services, or search and rescue services, or a not-for-profit non-governmental entity organized for the purpose of providing any such services, through the use of bona fide volunteers.

HC-DFS236 04-10
V1-ET

Employee

The term Employee means a full-time Employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 20 hours a week for the Employer. The term Employee may include officers, managers and Employees of the Employer, the bona fide volunteers if the Employer is an Emergency Service Provider, the partners if the Employer is a partnership, the officers, managers, and Employees of subsidiary or affiliated corporations of a corporation Employer, and the individual proprietors, partners, and Employees of individuals and firms, the business of which is controlled by the insured Employer through stock ownership, contract, or otherwise.

HC-DFS1096 01-18
ET1

Employer

The term Employer means the Policyholder and those affiliated employers whose Employees are covered under this Policy. The term Employer may include an Emergency Service Provider, any municipal or governmental corporation, unit, agency or department thereof, and the proper officers, as such, of an Emergency Service Provider or an unincorporated municipality or department thereof, as well as private individuals, partnerships, and corporations.

HC-DFS1594 01-21
ET

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

CERTIFICATE RIDER – Connecticut Residents

Rider Eligibility: Each Employee who is located in Connecticut

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Connecticut group insurance plans covering insureds located in Connecticut. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETCTRDR

Important Information

If the following text regarding "If Cigna determines….required to pay." is included in your **Important Information** section of your certificate, it does not apply to you.

Coupons, Incentives and Other Communications

If Cigna determines that you have used a coupon or other discount on a Prescription Drug Product made available by a pharmaceutical manufacturer or other source to pay any Copayment, Deductible, and/or Coinsurance payment(s), then Cigna may reduce your benefit under this plan accordingly. Such reduction may include excluding plan benefits in connection with the Prescription Drug Product from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Co-Insurance you are required to pay, and/or reducing the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts against which you credited the value of the coupon or other discount Cigna may require proof with your claim that you have made your required cost share payment(s) prior to the payment of any benefits by the plan.

HC-IMP265 08-19
V1 ET

Covered Expenses

Craniofacial Disorders

Coverage for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders shall be provided for individuals eighteen years of age or younger, if such processes and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association. No coverage shall be provided for cosmetic surgery.

HC-COV1222 01-22
ET3

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

If the following text "Provided further,….or other discount." is included in your certificate, it does not apply to you.

Provided further, if you use a coupon or other discount on a Prescription Drug Product made available by a pharmaceutical manufacturer or other source Cigna may reduce your benefit under the plan accordingly. Such reduction may include excluding plan benefits in connection with the Prescription Drug Product from accumulation toward any plan Deductible or Out-of- Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay, and/or reducing the benefits in proportion to the amount of Copayment, Deductible or Coinsurance amounts against which you credited the value of the coupon or other discount.

- the plan or policy shall not deny coverage for procedures, treatments or the use of any drug as experimental if such procedure, treatment or drug, for the illness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a phase III clinical trial of the federal Food and Drug Administration.
- surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) and craniofacial muscle disorders (other than treatment of craniofacial disorders for individuals 18 years of age or younger, as described in Covered Expenses).

HC-EXC479 01-22
ET3

Definitions

Dependent

Federal rights may not be available to Civil Union partners or Dependents.

Connecticut law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons of the opposite sex under federal law may not be available to parties to a civil union.

HC-DFS1673 01-22
ET3

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

CERTIFICATE RIDER – Florida Residents

Rider Eligibility: Each Employee who is located in Florida

The benefits of the policy providing your coverage are primarily governed by the law of a state other than Florida.

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Florida group insurance plans covering insureds located in Florida. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETFLRDR

Eligibility - Effective Date

Dependent Insurance

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included. For your Dependents to be insured for these benefits, you must elect the Dependent insurance for yourself no later than 30 days after you become eligible.

A newborn child will be covered for the first 31 days of life even if you fail to enroll the child. If you enroll the child after the first 31 days and by the 60th day after his birth, coverage will be offered at an additional premium. Coverage for an adopted child will become effective from the date of placement in your home or from birth for the first 31 days even if you fail to enroll the child. However, if you enroll the adopted child between the 31st and 60th days after his birth or placement in your home, coverage will be offered at an additional premium.

HC-ELG326 03-21
ET

Covered Expenses

- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: a baseline mammogram for women ages 35 through 39; a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; a mammogram every year for women age 50 and over; and one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician’s recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.
- charges made for diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint. Appliances and non-surgical treatment including for orthodontia are not covered.
- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.
- charges for general anesthesia and hospitalization services for dental procedures for an individual who is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.
- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.

- charges made for medical, surgical and Hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy. Services provided to you by a certified nurse-midwife or a licensed midwife, in a home setting or in a licensed birthing center. Coverage for a mother and her newborn child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. Post delivery care for a mother and her newborn shall be covered. Post delivery care includes: a postpartum assessment and newborn assessment, which can be provided at the hospital, the attending Physician's office, and outpatient maternity center or in the home by an Other Health Care Professional trained in mother and newborn care. The services may include physical assessment of the newborn and mother, and the performance of any clinical tests and immunizations in keeping with prevailing medical standards.
- charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: have vertebral abnormalities; are receiving long-term glucocorticoid (steroid) therapy; have primary hyperparathyroidism; have a family history of osteoporosis; and/or are estrogen-deficient individuals who are at clinical risk for osteoporosis.
- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be Medically Necessary by the Physician and in consultation with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.
- charges for newborn and infant hearing screening as well as any medically necessary follow-up evaluations leading to diagnosis and subsequent medically necessary treatment of a diagnosed hearing impairment.
- charges for the coverage of child health supervision services from birth to age 16. Child health supervision services are physician-delivered or supervised services that include periodic visits which include a history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests.

HC-COV1345 01-24
ET

Short-Term Rehabilitative Therapy and Spinal Manipulation Care Services

Any references to "Chiropractic Care" are hereby changed to "Spinal Manipulation".

HC-COV53 04-10
V1-ET

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by Cigna only to a person who:

- resides in a state that requires offering a conversion policy,
- is Entitled to Convert, and
- applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled to Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased but only if:

- you are not eligible for other individual insurance coverage on a guaranteed issue basis.
- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

If you retire, you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of

your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for other individual insurance coverage on a guaranteed issue basis, is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy

If you reside in a state that requires the offering of a conversion policy, the Converted Policy will be one of Cigna's current conversion policy offerings available in the state where you reside, as determined based upon Cigna's rules.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are Entitled to Convert, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

HC-CNV28 04-14
V1-ET

Exclusions, Expenses Not Covered and General Limitations

If the following text “Provided further,….required to pay.” is included in your certificate, it does not apply to you.

Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.

HC-EXC528 01-24
ET

Termination of Insurance

Special Continuation of Medical Insurance For Dependents of Military Reservists

If your insurance ceases because you are called to active military duty in: the Florida National Guard; or the United States military reserves, you may elect to continue Dependent insurance. You must pay the required premiums to the Policyholder if you choose to continue Dependent insurance. In no event will coverage be continued beyond the earliest of the following dates:

- the expiration of 30 days from the date the Employee's military service ends;
- the last day for which the required contribution for Dependent insurance has been made;
- the date the Dependent becomes eligible for insurance under another group policy. Coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is excluded from this provision;
- the date the Dependent becomes eligible for Medicare (this does not apply to Vision insurance);
- the date the group policy cancels;
- the date the Dependent ceases to be an eligible Dependent.

Reinstatement of Medical Insurance - Employees and Dependents

Upon completion of your active military duty in: the Florida National Guard; or the United States military reserves, you are entitled to the reinstatement of your insurance and that of your Dependents if continuation of Dependent insurance was not elected. Such reinstatement will be without the application of: any new waiting periods; or the Pre-existing Condition Limitation to any new condition that you or your Dependent may have developed during the period that coverage was interrupted due to active military duty.

Provisions Applicable to Reinstatement

- You must notify your Employer, before reporting for military duty, that you intend to return to Active Service with that Employer; and
- You must notify your Employer that you elect such reinstatement within 30 days after returning to Active Service with that Employer and pay any required premium.

Conversion Available Following Continuation

The provisions of the "Medical Conversion Privilege" section will apply when the insurance ceases.

HC-TRM131 01-18
ET

Medical Benefits Extension Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury, Sickness or pregnancy, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury, Sickness or pregnancy. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date a succeeding carrier agrees to provide coverage without limitation for the disabling condition;
- the date you are no longer Totally Disabled;
- 12 months from the date the policy is canceled; or
- for pregnancy, until delivery.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

HC-BEX42 04-11
ET

Definitions

Dependent – For Medical Insurance

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. Coverage is not required if the adopted child is ultimately not placed in your home.

A child includes a child born to an insured Dependent child of yours until such child is 18 months old.

HC-DFS1685 01-23
ET

Spinal Manipulation Care

The term Spinal Manipulation Care means the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

HC-DFS1684 01-23
ET

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

CERTIFICATE RIDER – Illinois Residents

Rider Eligibility: Each Employee who is located in Illinois

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Illinois group insurance plans covering insureds located in Illinois. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETILRDR

Important Notices

Illinois Notice

Notice to All Female Plan Members: Your Right to Select A Woman's Principal Health Care Provider

Illinois law allows you to select "a woman's principal health care provider" in addition to your selection of a Primary Care Physician. "A woman's principal health care provider" is a Physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice. "A woman's principal health care provider" may be seen for care without referrals from your Primary Care Physician. If you have not already selected "a woman's principal health care provider," you may do so now or at any other time. You are not required to have or to select "a woman's principal health care provider."

Your "woman's principal health care provider" must be a part of your plan. You may get the list of participating obstetricians, gynecologists, and family practice specialists from your Employer's employee benefits coordinator, or for your own copy of the current list, you may call the toll-free Member Services number on your ID card. The list will be sent to you within 10 days after your call. To designate "a woman's principal health care provider" from the list, call the toll-free Member Services number on your ID card and tell our staff the name of the Physician you have selected.

HC-IMP14 04-10
V1-ET

The Schedule

The provision “Mammograms, PSA, Pap Smear” in your medical schedule is amended to indicate the following:

If your medical plan is subject to a Lifetime Maximum or Preventive Care Maximum, Mammogram charges do not accumulate towards those maximums. In addition, In-Network Preventive Care Related (i.e. “routine”) Mammograms will be covered at “No charge”.

SCHEDIL-ETC

The Schedule

The provision “Mammograms, PSA, Pap Smear” in your medical schedule is amended to indicate the following:

In-Network Diagnostic Related Services (i.e. “non-routine” services) for Mammograms will be covered at 100% without application of any deductible, except if you’re covered under a Qualified High Deductible Health Savings plan then the plan deductible will apply.

SCHED IL ET-1

The Schedule

The provision “Skin Cancer Screening – one annual office visit for a whole body skin cancer screening examination” is hereby added to your medical schedule and is paid as follows:

In-Network Skin Cancer Screening will be covered at 100% without application of any deductible, except if you’re covered under a Qualified High Deductible Health Savings plan then the plan deductible will apply.

If your plan includes Out-of-Network coverage, Out-of-Network Skin Cancer Screening will be covered the same as any other Out-of-Network office visit.

SCHED IL ET-2

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient, except for 48/96 hour maternity stays;
- for Mental Health Residential Treatment Services.

HC-PAC111 01-20
V1 ET

Covered Expenses

- charges for colorectal cancer screening prescribed by a Physician, and follow-up colonoscopies when a follow-up colonoscopy is determined by a health care provider to be Medically Necessary.
- charges for ambulatory surgical facilities and associated anesthesia charges for dental care that is provided to a covered individual who: is a child age 6 or under; has a medical condition that requires hospitalization or general anesthesia for dental care; or is disabled.
- charges made, and anesthetics provided by a dentist with a permit by the IL Department of Financial and Professional Regulation to administer general anesthesia, deep sedation, or conscious sedation in conjunction with dental care that is provided to an insured in a dental office, oral surgeon's office, Hospital or ambulatory surgical treatment center if the individual is under age 26 and has been diagnosed with an Autism Spectrum Disorder or a Developmental Disability and has made 2 visits to the dental care provider prior to accessing this coverage.

  A person who is disabled refers to a person, regardless of age, with a chronic disability if the chronic disability meets all of the following conditions:

  - it is attributable to a mental or physical impairment or a combination of such impairments; and
  - it is likely to continue; and
  - it results in substantial functional limitations in one or more of the following areas of major life activity: self-care; receptive and expressive language, learning; mobility; capacity for independent living; or economic self-sufficiency.

  Autism Spectrum Disorders means as defined in Section 10 of the Autism Spectrum Disorders Reporting Act.

  Developmental Disability means a disability that is attributable to an intellectual disability or a related condition, if the related condition meets all of the following conditions:

  - it is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
  - it is manifested before the individual reaches age 22;
  - it is likely to continue indefinitely; and
  - it results in substantial functional limitations in 3 or more of the following areas of major life activity: self-care, language, learning, mobility, self-direction, and capacity for independent living.
- charges made for or in connection with low-dose mammography screening including breast tomosynthesis for detecting the presence of breast cancer. Coverage shall include: a baseline mammogram for women ages 35 to 39; an annual mammogram for women age 40 and older; and mammograms at intervals considered Medically Necessary for women less than age 40 who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors. Coverage also includes a comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches as well as a screening MRI when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches.

- low dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device and image receptor, with radiation exposure delivery of less than one rad per breast for two views of an average sized breast. This term also includes digital mammography and includes breast tomosynthesis. The term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.
- charges made for the removal of breast implants when the removal of the implant is Medically Necessary treatment for a Sickness or Injury.
- charges made for complete and thorough clinical breast exams performed by a Physician licensed to practice medicine in all its branches, an advanced practice nurse who has a collaborative agreement with a collaborating Physician that authorizes breast examinations, or a Physician assistant who has been delegated authority to provide breast examinations. Coverage shall include such an exam at least once every three years for women ages 20 to 40; and annually for women 40 years of age or older.
- charges for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including, but not limited to the use of intravenous immunoglobin therapy.

Virtual Care

Virtual Physician Services

Charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.

Assertive Community Treatment (ACT) and Community Support Team Treatment (CST treatment)

Charges for evidence-based treatment for the purpose of early treatment of a serious mental illness in a child or young adult under the age of 26.

Includes bundled health care services delivered through a multi-disciplinary team of mental health professionals to individuals who are experiencing severe and persistent symptoms from a serious mental illness.

Donated Breast Milk

If the covered person is an infant under the age of 6 months, and a licensed medical practitioner prescribes the milk for the covered person, and all of the following conditions are met:

- the milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health;
- the infant's mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated;
- the milk has been determined to be Medically Necessary for the infant; and
- one or more of the following applies:
  - the infant's birth weight is below 1,500 grams;
  - the infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis;
  - the infant has infant hypoglycemia;
  - the infant has congenital heart disease;
  - the infant has had or will have an organ transplant;
  - the infant has sepsis;
  - the infant has any other serious congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the infant;
- one or more of the following applies:
  - the child has spinal muscular atrophy;
  - the child's birth weight was below 1,500 grams and he or she has long-term feeding or gastrointestinal complications related to prematurity;
  - the child has had or will have an organ transplant; or
  - the child has a congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the child.

Long-term Antibiotic Therapy

Coverage for long-term antibiotic therapy, including necessary office visits and ongoing testing, for a person with a tick-borne disease when determined to be Medically Necessary and ordered by a Physician licensed to practice medicine in all its branches after making a thorough evaluation of the person's symptoms, diagnostic test results, or response to treatment. An experimental drug must be covered as a long-term antibiotic therapy if it is approved for an indication by the United States Food and Drug Administration. A drug, including an experimental drug, shall be covered for an off-label use in the treatment of a tick-borne disease if the drug has been approved by the United States Food and Drug Administration.

Skin Cancer Screening

Coverage for one annual office visit for a whole body skin examination for lesions suspicious for skin cancer.

HC-COV1234 01-22
ET

Durable Medical Equipment

Illinois requires coverage for cardiopulmonary monitors determined to be Medically Necessary for a person 18 years old or younger who has had a cardiopulmonary event.

HC-COV1035 01-21
ET

Prescription Drug Benefits

Covered Expenses

Prescription Drug List Exceptions

Cigna maintains a medical exceptions process which allows for the request of any clinically appropriate Prescription Drug Product when the:

- drug is not covered based on the plan's Prescription Drug List;
- plan is discontinuing coverage of the drug on the plan's Prescription Drug List for reasons other than safety or other than because the Prescription Drug Product has been withdrawn from the market by the drug's manufacturer;
- prescription drug alternatives required to be used in accordance with a step therapy requirement has been ineffective in the treatment of your disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics, and the known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance or has caused or, based on sound medical evidence, is likely to cause an adverse reaction or harm to you or your Dependent; or
- number of doses available under a dose restriction for the Prescription Drug Product has been ineffective in the treatment of your disease or medical condition or based on both sound clinical evidence and medical and scientific evidence, the known relevant physical and mental characteristics, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

Such medical exceptions procedures require, at a minimum, the following:

- any request for approval of coverage made verbally or in writing (regardless of whether made using a paper or electronic form or some other writing) at any time shall be reviewed by appropriate health care professionals;
- within 72 hours after receipt of a request either approve or deny the request. In the case of a denial, Cigna shall provide you or your authorized representative and your Physician with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial;
- an expedited coverage determination request must either be approved or denied within 24 hours after receipt of the request. In the case of a denial, Cigna shall provide you or your authorized representative and your Physician with the reason for the denial, an alternative covered medication, submitting an appeal to the denial.

Should your request for an exception be denied, you may refer to the “When You Have a Complaint or Appeal” section of this certificate which outlines the process to request that the original external exception request and the subsequent denial of that request be reviewed by an independent review organization.

A step therapy requirement exception request shall be approved if the: required Prescription Drug Product is contraindicated; you have tried the required Prescription Drug Product while under your current or previous health insurance or health benefit plan and the prescribing Physician submits evidence of failure or intolerance; or you are stable on a Prescription Drug Product selected by your Physician for the medical condition under consideration while on a current or previous health insurance or health benefit plan.

Once the exception request has been approved, the authorization for the coverage for the drug prescribed by your treating Physician, to the extent the prescribed drug is a covered drug under the plan up to the quantity covered and be made for 12 months following the approval or until renewal of the plan.

Epinephrine Injectors

Coverage for Medically Necessary epinephrine injectors for persons 18 years of age or under.

HC-PHR567 01-22
ET

Limitations

Step Therapy

Step therapy is not required for medications used in the treatment of substance use disorders. Cigna will process these medications in compliance with the requirements of the law.

HC-PHR568 01-23
ET

Definitions

Dependent – For Vision Benefits

Dependents include:

- your lawful spouse, including your civil union partner (The Religious Freedom Protection Act and Civil Union Act, 750 ILCS 75, allows both same-sex and different-sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples).

HC-DFS799 07-15
V1-ET1

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

CERTIFICATE RIDER – Maryland Residents

Rider Eligibility: Each Employee who is located in Maryland

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Maryland group insurance plans covering insureds located in Maryland. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETMDRDR

Important Notices

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You, your child's non-insuring parent, a state child support enforcement agency or the Maryland Department of Health and Mental Hygiene must notify your Employer and elect coverage for that child. If you yourself are not already enrolled, you must elect coverage for both yourself and your child. We will enroll both you and your child within 20 business days of our receipt of the QMCSO from your Employer.

Eligibility for coverage will not be denied on the grounds that the child: was born out of wedlock; is not claimed as a Dependent on the Employee's federal income tax return; does not reside with the Employee or within the plan's service area; or is receiving, or is eligible to receive, benefits under the Maryland Medical Assistance Program.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may

require a plan to comply with State laws regarding health care coverage.

Claims

Claims will be accepted from the non-insuring parent, from the child's health care provider or from the state child support enforcement agency. Payment will be directed to whoever submits the claim.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

Termination of Coverage Under a QMCSO

Coverage required by a QMCSO will continue until we receive written evidence that: the order is no longer in effect; the child is or will be enrolled under a comparable health plan which takes effect not later than the effective date of disenrollment; Dependent coverage has been eliminated for all Employees; or you are no longer employed by the Employer, except that if you elect to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage will be provided for the child consistent with the Employer's plan for postemployment health insurance coverage for Dependents.

HC-IMP215 01-16
ET1

The Schedule

The Medical Schedule is amended to remove any of the following OB/GYN notes if included:

Note: OB/GYN provider is considered a Specialist.

Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.

Note: Well-Woman OB/GYN visits will be considered a Specialist visit.

Note: Well-Woman OB/GYN visits will be considered either a PCP or Specialist depending on how the provider contracts with the Insurance Company.

The Medical Schedule is amended to indicate the following:

PSA, PAP Smear and Mandated Screening Tests

Screenings Include:

- Osteoporosis prevention and treatment including bone mass measurement

In addition, the following note will be included if your plan is exempt from Health Care Reform and a Preventive Care Maximum applies:

Note: Screenings are not subject to any Calendar or Contract Year Preventive Care maximum that applies to other Preventive Care Services.

The "**Outpatient Facility Services**" entry in the Medical Schedule is amended to read as follows:

Outpatient Facility Services

Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room and when provided instead of an inpatient service, when an attending physician's request for an inpatient admission has been denied.

The Medical Schedule is amended to include the following note in the "Delivery – Facility" provision of the "**Maternity Care Services**" section:

Note: Benefit levels will be the same as the benefit levels for Inpatient Hospital Facility Services for any other covered Sickness.

The Medical Schedule is amended to include the following provision, covered at "No charge", in the "**Maternity Care Services**" section:

Home Visits, as required by law and as recommended by the Physician

The Medical Schedule is amended to include the following provision, payable the same as any other illness:

Additional Benefits and Provisions

Calendar or Contract Year Maximum: Unlimited

Includes:

- Cleft Lip/Cleft Palate Services.
- Clinical Trials.

Note: Benefit levels for these additional benefits are subject to the same cost-sharing requirements as for any other similar covered service, depending on the type and place of the service provided.

The Medical Schedule is amended to include the following notes in the "**Mental Health and Substance Abuse**" sections identified:

Inpatient

Note: Benefit levels will be the same as the benefit levels for Inpatient Hospital Facility Services for any other covered Sickness.

Residential Crisis Services

Note: Benefit levels will be the same as the benefit levels for Inpatient Hospital Facility Services for any other covered Sickness.

Physician's Office Visit

Note: Benefit levels will be the same as the benefit levels for similar services for physical illnesses.

Partial Hospitalization and Outpatient Facility

Note: Benefit levels will be the same as the benefit levels for Outpatient Facility Services for any other covered Sickness.

SCHEDMD-ET1

The Schedule

If you are covered under a Qualified High Deductible Health Savings plan, the provision "Surgical Sterilization Procedures for Vasectomy (excludes reversals)." in your medical schedule is amended to indicate the following:

Surgical Sterilization Procedures for Vasectomy (excludes reversals). A Deductible for In-Network male vasectomy is only allowed in a high deductible health plan.

SCHED MD ET-24

Covered Expenses

- charges made for an outpatient service provided instead of an inpatient service, when an attending Physician's request for an inpatient admission is denied after utilization review has been conducted.
- charges for an objective second opinion, when required by a utilization review program.
- charges made for inpatient hospitalization services for a mother and newborn child for a minimum of: 48 hours on inpatient hospitalization care after an uncomplicated vaginal delivery; and 96 hours of inpatient hospitalization care after an uncomplicated cesarean section. A mother may request a shorter length of stay than that provided if the mother decides, in consultation with her attending provider, that less time is needed for recovery. If a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the Hospital, the insurer or nonprofit health service plan shall pay the cost of additional hospitalization for the newborn for up to 4 days.

  If the mother and newborn child have a shorter Hospital stay than that provided, coverage is provided for: one home visit scheduled to occur within 24 hours after Hospital discharge; and an additional home visit if prescribed by the attending provider. The home visit must: be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child; be provided by a registered Nurse with at least one year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and include any services required by the attending provider.

  If the mother and newborn child remain in the Hospital for at least the minimum length of time provided, coverage is provided for a home visit if prescribed by the attending provider. The home visit must: be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child; be provided by a registered Nurse with at least one year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and include any services required by the attending provider.

  Additionally, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn also remain in the Hospital, coverage will be provided for additional hospitalization for the newborn for up to four days.
- charges for inpatient or outpatient expenses for orthodontics; oral surgery; and otological, audiological and speech/language treatment involved in the management of cleft lip or cleft palate or both.
- charges made for testing of bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis when the bone mass measurement is requested by a health care provider for a qualified individual. A "qualified individual" means: an estrogen-deficient individual at clinical risk for osteoporosis; an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease; an individual receiving long-term glucocorticoid (steroid) therapy; an individual with primary hyperparathyroidism; or an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

HC-COV1088 01-21
V1-ET2

Clinical Trials

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate; or

- the individual provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered.

The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that meets **any** of the following criteria:

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Health Care Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
  - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
- or any of the following:
  - Department of Energy.
  - Department of Defense.
  - Department of Veterans Affairs.
- if **both** of the following conditions are met:
  - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
  - the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The cost incurred for drugs and devices that have been approved for sale by the FDA, whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

The plan does not cover any of the following services associated with a clinical trial:

- services that are not considered routine patient care costs and services, including the following:
  - the investigational drug, device, item, or service that is provided solely to satisfy data collection and analysis needs.
  - an item or service that is not used in the direct clinical management of the individual.
  - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- an item or service provided by the research sponsors free of charge for any person enrolled in the trial.
- travel and transportation expenses, unless otherwise covered under the plan, including but not limited to the following:
  - fees for personal vehicle, rental car, taxi, medical van, Ambulance, commercial airline, train.
  - mileage reimbursement for driving a personal vehicle.
  - lodging.
  - meals.
- routine patient costs obtained Out-of-Network when Out-of-Network benefits do not exist under the plan.

Examples of routine patient care costs and services include:

- radiological services;
- laboratory services;
- intravenous therapy;
- anesthesia services;
- Physician services;
- office services;
- Hospital services;
- Hospital Room and Board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

Clinical trials conducted only by Out-of-Network providers will be covered only when the following conditions are met:

- In-Network providers are not participating in the clinical trial;
- the clinical trial is conducted outside the individual's state of residence; or
- the qualified individual's plan provides coverage for Out-of-Network services.

Vision Benefits

For You and Your Dependents

Covered Expenses

Vision Benefits Extension Upon Coverage Termination

If you or your Dependent has ordered glasses or contact lenses before the date your or your Dependent's coverage under this benefit terminates, Cigna will continue to provide coverage for the glasses or contact lenses, in accordance with the terms of this benefit, if you or your Dependent; receive the glasses or contact lenses within 30 days after the order.

During an extension period described in this provision, no premium contribution will apply to your or your Dependent's coverage under this benefit.

This provision will not apply, however, if:

- coverage is terminated because an individual fails to pay a required premium;
- coverage is terminated for fraud or material misrepresentation by the individual; or
- any coverage provided by a succeeding vision benefit plan is provided at a cost to the individual that is less than or equal to the cost of the extended benefit required under this provision, and does not result in an interruption of benefits.

HC-VIS45 05-23
V1-ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed, and is being offered in a clinical trial approved by one of the following:

- the national institutes of health (NIH);
- an NIH cooperative group or an NIH center;
- the FDA in the form of an investigational new drug application;
- the federal department of veterans affairs; or
- an institutional review board of an institution in the state that has a multiple project assurance contract approved by the office of protection from research risks of the NIH.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition.

  However, charges made for a continuous course of dental treatment for an accidental Injury to teeth are covered. Also, facility charges and charges for general anesthesia or deep sedation which cannot be administered in a dental office are covered when Medically Necessary. Additionally, charges made by a Physician for any of the following surgical procedures are covered: excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a dentist other than the one who extracted the tooth). Charges for inpatient and outpatient services for orthodontics, oral surgery, and otologic, audiological, and speech/language treatment, involved with the management of the birth defect known as cleft lip or cleft palate, or both, are covered. Charges for diagnostic or surgical procedures involving a bone or joint of the face, neck or head if, under the accepted standards of the profession of the health care provider rendering the service, the procedure is Medically Necessary to treat a condition caused by congenital deformity, disease or Injury, are covered.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan. However, this exclusion does not apply to charges for inpatient hospitalization services and home visits, with respect to a newborn child, as provided in the "Covered Expenses" section.

HC-EXC445 01-21
ET1

Payment of Benefits

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right to: recover that overpayment from the provider or entity to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment within 18 months of the date the claim was paid if the benefits were subject to coordination of benefits; or within 6 months of the date the claim was paid for all other claims. Your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of

any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

When Cigna retroactively denies reimbursement, it will provide a written statement specifying the basis for the retroactive denial. If the retroactive denial results from COB, the written statement will provide the name and address of the carrier acknowledging responsibility for payment of the denied claims, unless retroactive denial results because: a) the information submitted to the carrier was fraudulent; b) the information submitted was improperly coded and Cigna provided sufficient information regarding the coding guidelines used to the provider at least 30 days prior to the date the services subject to retroactive denial were rendered; or c) the claim submitted was a duplicate claim.

If Cigna retroactively denies as a result of COB, the provider has 6 months from the date of the denial, unless Cigna permits a longer time period, to submit a claim for reimbursement to the carrier, the MD Medical Assistance Program or Medicare Program responsible for payment.

A claim may be considered improperly coded if the claim uses codes that do not conform with Cigna's coding guidelines as of the date the service or services were rendered or the claim does not otherwise conform with the contractual obligations of the provider that are applicable as of the date service or services were rendered.

HC-POB148 01-19
ET

Termination of Insurance

Employees

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. Coverage will be continued until the earlier of: the date you cease to be totally disabled; or 12 months after the date coverage terminates.

HC-TRM130 12-17
ET

Medical Benefits Extension Upon Coverage Termination

If the Medical Benefits under this plan cease for you or your Dependent due to the termination of your or your Dependent's coverage, and you or your Dependent is Totally Disabled on that date due to Injury or Sickness, or you or your Dependent is Confined in a Hospital, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury or Sickness until the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in The Schedule;
- the date you are neither Totally Disabled nor Confined in a Hospital; or
- 12 months after the date coverage ends.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when your or your Dependent's Medical Benefits cease.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

Cigna may, at any time, require you or your Dependent to provide proof of Total Disability.

This section will not apply, however, if: coverage is terminated because an individual fails to pay a required premium; coverage is terminated for fraud or material misrepresentation by the individual; or any coverage provided by a succeeding health benefit plan is provided at a cost to the individual that is less than or equal to the cost of the extended benefit required under this mandate, and does not result in an interruption of benefits.

Benefits Extension in Connection with Dental Care Services

Benefits for Covered Expenses incurred in connection with dental care services will be extended for 90 days after the date a person's coverage terminates. Covered Expenses will be deemed to be incurred while he or she is insured if the treatment:

- begins before the date coverage terminates; and

- requires two or more visits on separate days to a dentist's office.

HC-BEX4 04-10
V1-ET

Definitions

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Sickness also means cleft lip and cleft palate including inpatient and outpatient expenses arising from orthodontics, oral surgery, otologic, audiological and speech/language treatment in connection with that condition. Any dental exclusions will not apply to cleft lip and cleft palate. Further, expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

HC-DFS107 04-10
V1-ET

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

CERTIFICATE RIDER – Massachusetts Residents

Rider Eligibility: Each Employee who is located in Massachusetts

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Massachusetts group insurance plans covering insureds located in Massachusetts. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETMARDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

Any Dependent child including the newborn infant of a Dependent, an adopted child or foster child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

HC-ELG12 04-10
V1-ET

Important Notices

Mental Health Parity

This plan must cover the same or equal benefits for mental health and substance abuse conditions that it covers for other medical conditions. This is called "Mental Health Parity." For example, if your plan offers prescription drug benefits, whether drugs are prescribed for a mental health or medical condition, they must be covered at the same rates. The Copayments, Deductibles, and maximum lifetime benefits charged for mental health conditions must be the same as those for medical conditions.

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. Coverage for Mental Health Services includes treatment for the following:

- Biologically-based mental health disorders as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the DSM); specifically schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance abuse disorders, autism and any biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner of the Massachusetts Department of Mental Health in consultation with the commissioner of the Massachusetts Division of Insurance.
- Rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to commit rape, whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims.

- Nonbiologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM that substantially interferes with or substantially limits the functioning and social interactions of children and adolescents under age 19. The interference or limitation must either be: (a) documented by, and the referral for such diagnosis and treatment must be made by, the child or adolescent's Primary Care Provider, primary pediatrician or a licensed mental health professional; or (b) evidenced by conduct, including but not limited to, an inability to attend school as a result of the disorder; the need to hospitalize the child or adolescent as a result of the disorder; or a pattern of conduct or behavior caused by the disorder which poses a threat to the child or adolescent or to others. Benefits for treatment will continue beyond the adolescent's 19th birthday, if the adolescent is engaged in an ongoing course of treatment, until the course of treatment is completed, so long as this health benefits plan remains in effect. Ongoing treatment, if not completed, will also be covered under any subsequent health benefit plan in effect.
- All other mental disorders not otherwise previously provided for, which are described in the most recent edition of the DSM.

Psychopharmacological services and neuropsychological assessment services are covered on the same basis as services for any other Sickness.

In determining benefits payable, charges made for the treatment of biologically-based mental disorders, rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to commit rape, or nonbiologically-based mental, behavioral or emotional disorders of children or adolescents under age 19 are not considered Mental Health Services but are payable on the same basis as for any other Sickness.

Substance Use Disorder is considered a biologically-based mental disorder as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the DSM).

Your Rights Under Mental Health Parity

- You have the right to coverage for the diagnosis and Medically Necessary treatment of mental illness under the Mental Health Parity Law.
- You can change your doctor or other mental health provider if you are not satisfied.
- You can see and get a copy of your medical records. You can add your own notes to your records.
- You have the right to keep your medical information private.
- You can get a second medical opinion when you are given a diagnosis or treatment option.

Complaints Concerning Non-Compliance With Mental Health Parity

Complaints alleging a Carrier's non-compliance with Mental Health Parity may be submitted verbally or in writing to the Division's Consumer Services Section for review. A written submission may be made by using the Division's Insurance Complaint Form. A copy of the form may be requested by telephone or by mail, and form can also be found on the Division's webpage at:

http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html

Consumer complaints regarding alleged non-compliance with Mental Health Parity also may be submitted by telephone to the Division's Consumer Services Section by calling (877) 563-4467 or (617) 521-7794. All complaints that are initially made verbally by telephone must be followed up by a written submission to the Consumer Services Section, which must include but is not limited to the following information requested on the Insurance Complaint Form: the complainant's name and address; the nature of complaint; and the complainant's signature authorizing the release of any information regarding the complaint to help the Division with its review of the complaint. The Division will endeavor to resolve all consumer complaints regarding non-compliance with the Mental Health Parity Laws in a timely fashion.

HC-NOT111 01-19

ET

The Schedule

Short-Term Rehabilitative Therapy

Any maximum that applies to Short-Term Rehabilitative Therapy Services shown in The Schedule does not apply to Speech and Hearing Services.

External Prosthetic Appliances

If you are enrolled in a Network, Exclusive Provider Organization, or Open Access Plus In-Network medical plan, no separate External Prosthetic Appliances maximum or deductible will apply. External Prosthetic Appliances will be covered at "No charge".

If you are enrolled in a Network Point of Service medical plan, no separate External Prosthetic Appliances maximum or deductible will apply. In-Network External Prosthetic Appliances will be covered at "No charge".

If you are not enrolled in a Network, Network Point of Service, Exclusive Provider Organization, or Open Access Plus In-Network medical plan, any maximum that applies to External Prosthetic Appliances Services shown in The

Schedule does not apply to External Prosthetic Appliances meant to replace an arm or leg, in whole or in part.

Substance Abuse

The Schedule entry "Substance Abuse" is hereby changed to read "Substance Abuse" (a biologically-based mental disorder, payable on the same basis as for other sickness)".

For charges made for Substance Abuse, no separate maximums will apply and Covered Expenses will be payable the same as for other illnesses, including accumulation to any Out-of-Pocket amount and any increase to 100% once the Out-of-Pocket amount has been reached. Outpatient Substance Abuse charges will be paid at the same level as the Primary Care Provider's Office visit.

SCHEDMA-ET1

Covered Expenses

- charges for Emergency Services. When you are confronted with an emergency medical condition, you should call the emergency telephone access number – 911, or its local equivalent.
- charges made for or in connection with mammograms for breast cancer screening, not to exceed: one baseline mammogram for women age 35 but less than 40, and a mammogram annually for women age 40 and over.
- charges made for an annual Papanicolaou laboratory screening test.
- charges for abortions and abortion-related care.

Covered Expenses include expenses incurred at any of the Approximate Intervals shown below for a Dependent child who is age 5 or less for charges made for Child Preventive Care Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

- a history; physical examination; development assessment; anticipatory guidance; and appropriate immunizations and laboratory tests;
- measurements; sensory screening; neuropsychiatric evaluation; hereditary and metabolic screening at birth; TB test; hematocrit; other appropriate blood tests and urinalysis; special medical formulas approved by the Commissioner of Public Health, prescribed by a Physician, and Medically Necessary for treatment of PKU, tyrosinemia, homocystinuria, maple syrup urine disease, and propionic acidemia or methylmalonic acidemia in infants and children or Medically Necessary to protect the unborn fetuses of pregnant women with PKU.

Excluding any charges for:

- more than one visit to one provider for Child Preventive Care Services at each of the Approximate Intervals up to a total of 12 visits for each Dependent child;
- services for which benefits are otherwise provided under this Medical Benefits section;
- services for which benefits are not payable according to the Expenses Not Covered section.

Approximate Intervals are:

- six times during the first year of life.
- three times during the second year of life.
- annually each year thereafter through the fifth year of life.

Covered Expenses also include expenses incurred for Dependent children from birth until the child's third birthday for early intervention services, up to the Medically Necessary early intervention services maximum shown in The Schedule, to include: occupational, physical and speech therapy, nursing care and psychological counseling.

These services must be delivered by certified early intervention specialists, as defined by the early intervention operational standards by the Massachusetts Department of Public Health and in accordance with applicable certification requirements.

- charges made for or in connection with the treatment of metastatic breast cancer by bone marrow transplants provided the treatment follows the guidelines reviewed and approved by the National Cancer Institute.
- charges for a scalp hair prosthesis worn for hair loss due to the treatment of any form of cancer or leukemia, provided that a Physician verifies in writing that the scalp hair prosthesis is Medically Necessary.
- charges for a newborn hearing screening test performed before the newborn is discharged from the Hospital or birthing center.
- charges for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome including, but not limited to, the use of intravenous immunoglobulin therapy.
- charges made for screening for lead poisoning of a Dependent child from birth until 6 years of age.
- charges for Medically Necessary diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists, if such services are rendered within the lawful scope of practice for such practitioners, regardless of whether the services are provided in a Hospital, clinic or private office, and if such coverage does not extend to the diagnosis or

treatment of speech, hearing and language disorders in a school-based setting.

- charges for treatment of an Injury or Sickness of an eligible newborn or adopted child, including the necessary care and treatment of medically-diagnosed congenital defects and birth abnormalities or premature birth.
- charges for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section for a mother and her newborn child. Any decision to shorten such minimum coverage will be made in accordance with rules and regulations promulgated by the Massachusetts Department of Public Health relative to early discharge (less than 48 hours for a vaginal delivery and 96 hours for a caesarean delivery) and post-delivery care, including but not limited to: home visits; parent education; assistance and training in breast or bottle feeding; and the performance of any necessary and appropriate clinical tests. The first home visit may be conducted by a registered nurse, Physician or certified nurse-midwife. Any subsequent home visit determined to be clinically necessary must be provided by a licensed health care provider.
- charges for the diagnosis and treatment of autism spectrum disorder. Autism spectrum disorders are any of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. These disorders include: autistic disorder; Asperger's disorder; and pervasive developmental disorders not otherwise specified.

  Diagnosis includes the following: Medically Necessary assessments; evaluations, including neuropsychological evaluations; genetic testing; or other tests to diagnose whether an insured has one of the autism spectrum disorders.

  Treatment includes the following care when prescribed, provided or ordered by a licensed Physician or licensed Psychologist who determines the care to be Medically Necessary:

  - Habilitative or Rehabilitative;
  - Pharmacy;
  - Psychiatric;
  - Psychological; and
  - Therapeutic.

  Habilitative or Rehabilitative care means professional counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual. Applied behavior analysis includes the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

  Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

  Psychological care means direct or consultative services provided by a Psychologist licensed in the state in which the Psychologist practices.

  Therapeutic care includes services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

  Pharmacy care is included to the same extent that such care is provided by the Policy for other medical conditions.

  The guidelines used by Cigna to determine if coverage for the diagnosis and treatment of autism spectrum disorder is Medically Necessary will be:

  - developed with input from practicing Physicians in the insurer's service area;
  - developed in accordance with the standards adopted by national accreditation organizations;
  - updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
  - evidence-based, if practicable.

  In applying such guidelines, Cigna will consider the individual health care needs of the insured.

  Benefits are payable on the same basis as for the diagnosis and treatment of other physical conditions. No annual or lifetime visit or dollar limits apply to the diagnosis and treatment of autism spectrum disorder, nor will Cigna require that visits for the diagnosis and treatment of autism spectrum disorder be completed within a fixed number of days.

  No coverage is provided for services to an individual under: an individualized family service plan; an individualized education program; an individualized service plan; or for services related to autism spectrum disorder provided by school personnel under an individualized education program.
- charges made for hormone replacement therapy services for peri- and postmenopausal women and for outpatient contraceptive drugs or devices which have been approved by the Food and Drug Administration (FDA), under the same terms and conditions as for other outpatient prescription drugs and devices.

- charges made for cardiac rehabilitation, according to standards developed by the Massachusetts Department of Public Health. Cardiac rehabilitation means a multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease, provided in either a Hospital or other setting and meeting standards set forth by the Massachusetts Commissioner of Public Health.
- charges for Medically Necessary diabetes-related items and services:
  - Diabetes self-management training and education, including medical nutrition therapy when provided by a certified diabetes health care provider.
  - Laboratory tests, including glycosylated hemoglobin or HbAlc, urinary protein/microalbumin and lipid profiles.
  - Durable medical equipment:
    - Blood glucose monitors;
    - Voice synthesizers for blood glucose monitors for use by the legally blind;
    - Visual magnifying aids for the legally blind.
- Prosthetics:
  - Therapeutic/molded shoes and shoe inserts (when certified by the treating Physician and prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist or pedorthist).
- coverage for the cost of HLAT or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. Coverage includes the cost of testing for A, B, or DR antigens, or any combination thereof, consistent with rules, regulations, and criteria established by the Department of Public Health.
- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage of oral contraceptives.
- charges for medical or drug treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome including, but not limited to reconstructive surgery, such as suction assisted lipectomy, other restorative procedures and dermal injection or fillers for reversal of facial lipoatrophy syndrome.

Nutritional Counseling

- charges for counseling when diet is a part of the medical management of a medical or behavioral condition.

Enteral Nutrition

Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes:

- charges made for nonprescription enteral formulas to treat malabsorption caused by Crohn's disease or ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited/inborn disorders of amino and organic acid metabolism.
- charges for foods modified to be low protein for use by a person with disorders of amino and organic acid metabolism.

Mental Health and Substance Use Disorder Services

Mental health services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. Coverage for mental health services includes treatment for the following:

- biologically-based mental disorders as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the DSM); specifically schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post traumatic stress disorder, substance use disorders, autism and any biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner of the Massachusetts Department of Mental Health in consultation with the commissioner of the Massachusetts Division of Insurance.
- rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to commit rape, whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims.
- non-biologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM that substantially interferes with or substantially limits the functioning and social interactions of children and adolescents under age 19. The interference or limitation must either be: documented by, and the referral for such diagnosis and treatment must be made by, the child or adolescent's Primary Care Provider, primary pediatrician or a licensed mental health professional; or evidenced by conduct, including but not limited to, an inability to attend school as a result of the disorder; the need to hospitalize the child or adolescent as a result of the disorder; or a pattern of conduct or behavior caused by the disorder which poses a threat to the child or adolescent or to others. Benefits for

treatment will continue beyond the adolescent's 19th birthday, if the adolescent is engaged in an ongoing course of treatment, until the course of treatment is completed, so long as this health benefits plan remains in effect. Ongoing treatment, if not completed, will also be covered under any subsequent health benefit plan in effect.

- coverage for mental health or substance use disorder services that are delivered through the psychiatric collaborative care model.
- all other mental disorders not otherwise previously provided for, which are described in the most recent edition of the DSM.

Psychopharmacological services and neuropsychological assessment services are covered on the same basis as services for any other Sickness.

In determining benefits payable, Charges made for the treatment of biologically-based mental disorders, rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to commit rape, or non-biologically-based mental, behavioral or emotional disorders of children or adolescents under age 19 are not considered mental health services but are payable on the same basis as for any other Sickness.

Substance Use Disorder is considered a biologically-based mental disorder as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the DSM).

Inpatient Services

Inpatient Services are services that are provided on a 24-hour basis while you or your Dependent is Confined in a general Hospital, a facility under the direction of the Department of mental health, a private mental Hospital licensed by the Department of mental health, or a substance use disorder facility licensed by the Department of Public Health for the treatment and evaluation of mental health.

Intermediate Services

Intermediate Services are a range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are insufficient to meet a patient's needs. Intermediate Services include, but are not limited to, the following (as defined by Massachusetts law):

- Acute and other residential treatment.
- Clinically managed detoxification services.
- Partial hospitalization.
- Intensive Outpatient Programs (IOP).
- Day treatment.
- Crisis stabilization.

Outpatient Services

Outpatient Services are services provided in person in an ambulatory care setting. Outpatient Services may be provided in a licensed Hospital, a mental health or substance use disorder clinic licensed by the Department of Public Health, a public community mental health center, a professional office, or home-based services. Such services delivered in such offices or settings are to be rendered by a licensed mental health professional (a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a licensed mental health counselor; or a licensed nurse mental health clinical specialist, a clinician practicing under the supervision of a licensed professional and working towards licensure in a clinic licensed under public health statutes (chapter 111), a licensed alcohol and drug counselor I, as defined in section 1 of chapter 111J, or a licensed marriage and family therapist within the lawful scope of practice for such therapist) acting within the scope of his or her license.

Mental Health and Substance Use Disorder Services for Children and Adolescents

Coverage includes diagnosis and treatment of child-adolescent mental health disorders which substantially interfere with or substantially limit the functioning and social interactions of the child or adolescent. The interference or limitation must be documented by, and the referral for the diagnosis and treatment must be made by the child's Primary Care Provider, primary pediatrician, or a licensed mental health professional. Alternatively, a child or adolescent may be referred for diagnosis and treatment when there is:

- an inability to attend school as a result of such a disorder;
- the need to hospitalize the child or adolescent as a result of the disorder; or
- a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

Child-adolescent mental health services must take place in the least restrictive clinically appropriate setting and must consist of a range of inpatient, intermediate, and outpatient services. Medically Necessary, active care that is expected to lead to improvement of the condition in a reasonable period of time, as well as Medically Necessary non-custodial treatment for the mental health disorders is a covered expense. Educational services to improve an individual's academic performance or developmental functioning are not required services under the benefit mandate for mental health services.

Intermediate Services

Intermediate Services are a range of non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are insufficient to meet a patient's needs. Intermediate Services include, but are

not limited to, the following (as defined by Massachusetts law):

- community-based acute treatment (CBAT) are mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to: daily medication monitoring; psychiatric assessment; nursing availability; 1:1 nursing care (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from inpatient services.
- intensive community-based acute treatment (ICBAT) provides the same services as CBAT for children and adolescents but of higher intensity, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery. ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat children and adolescents with clinical presentations similar to those referred to inpatient mental health services but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT directly from the community as an alternative to inpatient hospitalization; ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting.

Outpatient Services

Outpatient Services are services provided in person in an ambulatory care setting. Outpatient Services may be provided in a licensed Hospital, a mental health or substance use disorder clinic licensed by the Department of Public Health, a public community mental health center, a professional office, or home-based services. Such services delivered in such offices or settings are to be rendered by a licensed mental health professional (a licensed physician who specializes in the practice of psychiatry; a licensed psychologist; a licensed independent clinical social worker; a mental health counselor; or a licensed nurse mental health clinical specialist) acting within the scope of his or her license.

- In-home therapy is Medically Necessary therapeutic clinical intervention or ongoing training, as well as therapeutic support; provided however, that the intervention or support shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting.
- In-home behavioral services are a combination of Medically Necessary behavior management therapy and behavior management monitoring; provided, however, that such services shall be available, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting.
- Mobile crisis intervention services are a short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, 7 days a week to a child experiencing a behavioral health crisis. Mobile crisis intervention is used to identify, assess, treat and stabilize a situation, to reduce the immediate risk of danger to the child or others, and to make referrals and linkages to all Medically Necessary behavioral health services and supports and the appropriate level of care. The intervention shall be consistent with the child's risk management or safety plan, if any. Mobile crisis intervention includes a crisis assessment and crisis planning, which may result in the development or update of a crisis safety plan.
- Intensive care coordination is a collaborative service that provides targeted case management services to children and adolescents with a serious emotional disturbance, including individuals with co-occurring conditions, in order to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality, cost-effective outcomes. This service includes an assessment, the development of an individualized care plan, referrals to appropriate levels of care, monitoring of goals, and coordinating with other services and social supports and with state agencies, as indicated. The service shall be based upon a system of care philosophy and the individualized care plan shall be tailored to meet the needs of the individual. The service shall include both face-to-face and telephonic meetings, as indicated and as clinically appropriate. ICC is delivered in office, home or other settings, as clinically appropriate.
- Family support and training are Medically Necessary services provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to improve or resolve the child's emotional or behavioral needs; this service must be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Family support and training addresses one or more goals on the youth's behavioral health treatment plan and may include educating parents/caregivers about the youth's behavioral health needs and resiliency factors, teaching parents/caregivers how to navigate services on behalf of the child and how to identify formal and informal services and supports in their communities, including parent support and self-help groups.
- Therapeutic mentoring services are Medically Necessary services provided to a child, designed to support age-appropriate social functioning or to improve deficits in the child's age-appropriate social functioning resulting from a DSM diagnosis; these services may include supporting, coaching, and training the child in age-appropriate

behaviors, interpersonal communication, problem solving, conflict resolution, and relating appropriately to other children and adolescents and to adults. Such services must be provided, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service addressing one or more goals on the youth's behavioral health treatment plan. It may also be delivered in the community, to allow the youth to practice desired skills in appropriate settings.

Exclusions

The following are specifically excluded from mental health and substance use disorder services:

- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

HC-COV1395 01-24
ET

External Prosthetic Appliances and Devices

Scalp Hair Prostheses

Scalp hair prosthesis worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia, if such coverage is in accordance with a written statement by a Physician that the prosthesis is Medically Necessary.

HC-COV1074 01-21
ET

Infertility Services

- charges made for services related to:
  - diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed;
  - charges made for intrauterine insemination and artificial insemination related to enabling conception regardless of an infertility diagnosis;
  - access to harvesting of sperm and oocytes for the purposes of cryopreservation and short-term storage.
- Services include, but are not limited to: infertility drugs, approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination and intrauterine insemination (IUI); diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization and embryo transfer (IVF-ET); sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor’s insurance (if any); intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility; zygote intrafallopian transfer (ZIFT); assisted hatching; cryopreservation of eggs; and the services of an embryologist.

Infertility is defined as:

- the condition of an individual who is unable to conceive or produce conception during a period of one year for a female who is age 35 or younger, or during a period of 6 months for a female over age 35. If a person conceives, but is unable to carry that pregnancy to live birth, the period of time a woman attempted to conceive prior to achieving that pregnancy will be included in the calculation of the one year or 6 month period, as applicable.

This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are excluded infertility services:

- donor charges and services.

HC-COV1085 01-24
ET

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that may be administered in an Inpatient setting, Outpatient setting, Physician’s office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals that, because of their characteristics as determined by Cigna, require a qualified licensed health care professional to administer or directly supervise administration.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to

step therapy requirements. This means that in order to receive coverage, the covered person may be required to try a specific Medical Pharmaceutical before trying others. Medical Pharmaceuticals administered in an Inpatient facility are reviewed per Inpatient review guidelines.

Cigna determines the utilization management requirements and other coverage conditions that apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to:

- Clinical factors, which may include but are not limited to Cigna's evaluations of the site of care and the relative safety or relative efficacy of Medical Pharmaceuticals.
- Economic factors, which may include but are not limited to the cost of the Medical Pharmaceutical and assessments of cost effectiveness after rebates.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

Certain Medical Pharmaceuticals that are used for treatment of complex chronic conditions, are high cost, and are administered and handled in a specialized manner may be subject to additional coverage criteria or require administration by a participating provider in the network for the Cigna Pathwell Specialty Network. Cigna determines which injections, infusions, and implantable drugs are subject to these criteria and requirements.

The Cigna Pathwell Specialty Network includes but is not limited to contracted physician offices, ambulatory infusion centers, home and outpatient hospital infusion centers, and contracted specialty pharmacies. When the Cigna Pathwell Specialty Network cannot meet the clinical needs of the customer as determined by Cigna, exceptions are considered and approved when appropriate.

A complete list of those Medical Pharmaceuticals subject to additional coverage criteria or that require administration by a participating provider in the Cigna Pathwell Specialty Network is available at www.cigna.com/PathwellSpecialty.

The following are not covered under the plan, including but not limited to:

- Medical Pharmaceutical regimens that have a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s);
- Medical Pharmaceuticals newly approved by the Food & Drug Administration (FDA) up to the first 180 days following its market launch;
- Medical Pharmaceutical regimens for which there is an appropriate lower cost alternative for treatment.

In the event a covered Medical Pharmaceutical is not clinically appropriate, Cigna makes available an exception process to allow for access to non-covered drugs when Medically Necessary.

Cigna may consider certain Medical Pharmaceutical regimens as preferred when they are clinically effective treatments and the most cost effective. Preferred regimens are covered unless the covered person is not a candidate for the regimen and a Medical Necessity coverage exception is obtained.

HC-COV1397 01-24

ET

The Schedule

The pharmacy schedule is amended to add the following:

Generic FDA approved tobacco cessation products are not subject to the deductible, copay or coinsurance.

SCHEDPHARM90-maet

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs. Note: This exclusion does not apply to scalp hair prosthesis worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia. For more information about this coverage for scalp hair prosthesis, see the Covered Expenses section.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.

HC-EXC543 01-24

ET

Termination of Insurance – Continuation

Medical Insurance for Former Spouse

A covered former spouse is entitled to continue coverage following a final court decree granting divorce or separate support, until the earliest of the following:

- the date you fail to make any required contribution;
- the date you are no longer insured under the group policy;
- the date Dependent Insurance cancels;
- the date your former spouse remarries;
- the date you remarry, unless you make arrangements with the Employer to continue the insurance in accordance with the paragraph below entitled "Effect of Remarriage of Employee";
- the date the court judgment no longer requires continued coverage.

Effect of Remarriage of Employee

If you remarry, an additional contribution will be required for your former spouse. You must notify your Employer of your remarriage within 30 days of the date of your remarriage and pay the additional contribution.

Special Continuations of Medical Insurance

If your Medical Insurance terminates for the reason listed below, the Medical Insurance for you and your Dependents may be continued as outlined.

Involuntary Layoff

Medical Insurance for you and your Dependents will be continued until the earlier of: 39 weeks from the date your Active Service ends, or as shown in (1), (2) or (3) of the "Other Dates of Termination" section; upon payment of the required premium by you to your Employer.

Plant Closing

In the case of a plant closing, or a partial closing as determined by law, the Medical Insurance for you and your Dependents will be continued until the earlier of: 90 days from the date your Active Service ends; or as shown in (1), (2), or (3) of the "Other Dates of Termination" section. For continuation to take effect: you must continue to pay any portion of the premium for which you were responsible prior to the end of your Active Service; and your Employer must continue to pay any portion of the premium for which he was responsible before the plant closing or partial closing. If the insurance terminates because your Employer fails to pay the premium, he will be liable for any Covered Expenses incurred between the last premium payment and the end of the 90-day continuation period.

Any current collective bargaining agreement with an extension at least equal to the continuation outlined here, will prevail.

After Your Death

Medical Insurance for your Dependents will be continued until the earliest of: 39 weeks from the date your insurance ceases, or as shown in (2), or (3) of the "Other Dates of Termination" section, if the required payment is made to the Employer.

Other Dates of Termination

(1) The date you become eligible for Medical Insurance under any other group policy or Medicare;

(2) The last day of a period equal to the most recent time period during which you were insured under the Employer's policy, or, in the case of Dependent Medical Insurance continuation, a period equal to the most recent time period during which you were insured for your Dependents under the Employer's policy;

(3) With respect to any one Dependent, the earlier of: the date that Dependent becomes eligible for Medical Insurance under another group policy or under Medicare, or the date that Dependent no longer qualifies as a Dependent for any reason other than your death.

Special 31-Day Continuation

Upon payment of premium by your Employer, your insurance will continue for 31 days after you:

- cease to be in a Class of Eligible Employees or cease to qualify as an Employee.
- terminate employment for any reason.

In no case will the insurance continue after you become insured under any other group policy for similar benefits or after the last day for which you have made any required contribution for the insurance.

HC-TRM18 04-10
V1-ET

Definitions

Dependent

Dependents include:

- your former spouse, unless the divorce decree provides otherwise.

A child includes:

- a legally adopted child. Coverage for an adopted child will begin: on the date of the filing of a petition to adopt such a child, provided the child has been residing in your home as a foster child, and for whom you have been receiving foster care payments; or when a child has been placed in your home by a licensed placement agency for purposes of adoption;
- a stepchild who lives with you; and

- a child born to one of your Dependent children, as long as your grandchild is living with you and: your Dependent child is insured; or your grandchild is primarily supported by you.

HC-DFS1686 01-23
ET

Prescription Drug Product

The following diabetic supplies: blood glucose monitoring strips for home use, urine glucose strips, ketone strips, lancets, insulin, insulin syringes, prescribed oral diabetes medications that influence blood sugar levels, insulin pumps and insulin pump supplies, insulin "pens".

HC-DFS1831 01-24
ET

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

CERTIFICATE RIDER – Michigan Residents

Rider Eligibility: Each Employee who is located in Michigan

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Michigan group insurance plans covering insureds located in Michigan. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETMIRDR

Important Notices

Managed Care Disclosure

If you are currently insured for benefits under this plan, you may request information from Cigna as follows by written request only:

- detailed provider information including those not accepting new patients, practice type or specialty, and limitation of accessibility.
- professional credentials of providers participating in the plan.
- the Michigan Office of Financial and Insurance Regulation telephone number to obtain information regarding complaints and disciplinary action.
- detailed drug formulary information.
- information regarding financial relationship between Cigna and any closed provider panel.
- a telephone number for additional information in regard to the above.

HC-IMP91 04-10
V1-ET

The Schedule

The paragraph “Out-of-Network Emergency Services Charges” in your medical schedule is amended to indicate the following:

Out-of-Network Emergency Services Charges

For services rendered in Michigan - If Emergency Services are rendered in Michigan, the allowable amount used to determine the Plan’s benefit payment for services of an Out-of-Network provider in an In-Network or Out-of-Network facility may be based on an agreed-upon or negotiated rate, the greater of (i) the median amount negotiated by Cigna for the region and provider specialty as determined by Cigna; or (ii) 150% of the Medicare fee schedule payment rate for the same or similar service in the same geographic area. If the provider and Cigna cannot agree on an allowable amount, the provider may request arbitration pursuant to Michigan law. The provider may not attempt to collect from you any amount in excess of applicable cost-sharing amounts (any applicable deductible, copay or coinsurance) based upon the allowable amount. Following arbitration, your cost-share may be recalculated to reflect a reduction or increase in the allowable amount determined by arbitration.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges that may be made in excess of the allowable amount, except as described above for

services rendered in Michigan. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

The medical schedule is amended to add the following paragraph:

Out-of-Network Surprise Bill Charges (Non-Emergency)

If services are rendered in Michigan, and you inadvertently receive covered non-Emergency services from an Out-of-Network provider as part of covered services rendered in an In-Network facility (i.e., an Out-of-Network surprise bill), contact Cigna Customer Service at the phone number on your ID card.

The allowable amount used to determine the Plan's benefit payment may be based on an agreed upon or negotiated amount, the greater of: (i) the median amount negotiated by Cigna for the region and provider specialty as determined by Cigna; or (ii) 150% of the Medicare fee schedule payment rate for the same or similar service in the same geographic area.

The provider may not attempt to collect from you any amount in excess of applicable cost-sharing amounts (any applicable deductible, copay or coinsurance) based upon the allowable amount.

SCHEDMI-ETC

The Schedule

The Medical Schedule is amended to indicate that no separate maximum/deductible shall apply to **Diabetic Equipment**.

The **Nutritional Evaluation** annual maximum shown in the Medical Schedule is amended to indicate the following:

"3 visits per person however, the 3 visit limit will not apply to treatment of diabetes."

SCHEDDENE-ET1

Covered Expenses

Autism Spectrum Disorder

- charges made for professional services for the diagnosis and treatment of Autism Spectrum Disorders, including Behavioral Health Treatment, Applied Behavior Analysis (ABA), Psychiatric care, Psychological care, Therapeutic care, and Pharmacy benefits (if plan includes prescription drug coverage) that develop, maintain, or restore to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder.

Cigna, as a condition of coverage may:

- require a review of the treatment consistent with current protocols and may, at its own expense, require a review of the Treatment plan;
- request the results of the Autism Diagnostic Observation Schedule that has been used in the diagnosis of an Autism Spectrum Disorder;
- request that the Autism Diagnostic Observation Schedule be performed not more frequently than once every three years; and
- request that an annual development evaluation be conducted and the results of that annual development evaluation be submitted to Cigna.

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism Diagnostic Observation Schedule means the protocol available through western psychological services for diagnosing and assessing Autism Spectrum Disorders or any other standardized diagnostic measure for Autism Spectrum Disorders that is approved by the commissioner of insurance, if the commissioner of insurance determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

Autism Spectrum Disorders means Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder not otherwise specified, in accordance with the Diagnostic and Statistical Manual (DSM).

Behavioral Health Treatment means evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

- are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
- are provided or supervised by a board certified behavior analyst or a licensed Psychologist so long as the services performed are commensurate with the Psychologist's formal university training and supervised experience.

HC-COV1238 01-22 ET

Medical Pharmaceuticals

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician or Other Health Professional. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

HC-COV1239 01-22
ET

Prescription Drug Benefits

Limitations

Prescription Eye Drops Refills

If the following conditions are met the refill prescription will be covered:

(a) For a 30-day supply, once 23 days have passed after either of the following:
- The original date the prescription was distributed to you.
- The date the most recent refill was distributed to you.

(b) The prescriber indicates on the original prescription that additional quantities are needed.

(c) The prescription eye drops prescribed by the prescriber are covered under the plan.

HC-PHR375 01-20
ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. The plan or policy shall not deny coverage for a drug therapy or device as experimental, investigational and unproven if the drug therapy or device is otherwise approved by the FDA to be lawfully marketed and is recognized for treatment of the prescribed indication in any one of the following: The American Medical Association Drug Evaluation; The American Hospital Formulary Service Drug Information; The United States Pharmacopoeia Drug Information or any two articles from major peer-reviewed medical journals.
- non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.

- expenses incurred by a participant to the extent reimbursable under automobile insurance coverage. Coverage under this plan is secondary to automobile no-fault insurance or similar coverage, except the coverage under this plan is primary to a Michigan automobile no-fault insurance policy issued to a Michigan resident if that automobile policy coordinates with or states that it is secondary to group health insurance.

HC-EXC490 01-22
ET

Definitions

Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of benefits under the plan, this definition may also include products in the following categories if specifically identified on the Prescription Drug List:

- Certain durable products and supplies that support drug therapy.
- Certain diagnostic testing and screening services that support drug therapy.
- Certain medication consultation and other medication administration services that support drug therapy.
- Certain digital products, applications, electronic devices, software and cloud-based service solutions used to predict, detect and monitor health conditions in support of drug therapy.
- Medication used in the treatment of the feet, ankles or nails associated with diabetes.

HC-DFS1689 01-22
ET

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

CERTIFICATE RIDER – Montana Residents

Rider Eligibility: Each Employee who is located in Montana

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Montana group insurance plans covering insureds located in Montana. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETMTRDR

Covered Expenses

- charges made by a Hospital for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following delivery by cesarean section for a mother and newborn infant.
- charges for one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;
- charges for a mammogram every 2 years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's Physician; and
- charges for a mammogram each year for a woman who is 50 years of age or older.
- charges made for well-child care benefits for Dependent children from birth through age seven. Coverage must include a history, physical examination, developmental assessment and anticipatory guidance as published by the American Academy of Pediatrics, laboratory tests and routine immunizations according the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. Department of Health and Human Services for immunization against: diphtheria; haemophilus influenzae type b; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella;

rotovirus; and any other immunization that is required by law for a child. Services must be provided during the course of one visit by or under the supervision of a single provider.

- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges made for acupuncture/acupressure when medically appropriate for the treatment of an illness or Injury.
- charges made for Telemedicine. Telemedicine means the use of interactive audio, video, or other telecommunications technology that is: used by a health care provider or health care facility to deliver health care services at a site other than the site where the patient is located; and delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996.

  Telemedicine includes the use of electronic media for consultation relating to the health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile transmissions.

Autism

Charges for diagnosis and treatment of Autism Spectrum Disorders for a covered child. Coverage must be provided to a child who is diagnosed with one of the following disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

- autistic disorder;
- Asperger's disorder; or
- pervasive developmental disorder not otherwise specified.

Coverage under this section includes:

- habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed Physician or licensed Psychologist, including but not limited to professional, counseling, and guidance services and treatment programs that are Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child;
- medications prescribed by a Physician licensed under Title 37, chapter 3;
- psychiatric or psychological care; and
- therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist licensed in this state.

  Habilitative and rehabilitative care includes Medically Necessary interactive therapies derived from evidence-based research, including applied behavior analysis, which is also known as Lovaas therapy, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

  Applied behavior analysis covered under this section must be provided by an individual who is licensed by the behavior analyst certification board or is certified by the Department of Public Health and Human Services as a family support specialist with an autism endorsement.

  When treatment is expected to require continued services, Cigna may request that the treating Physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is Medically Necessary. The treatment plan must be based on evidence-based screening criteria. Cigna may ask that the treatment plan be updated every 6 months.

  As used in this section, "Medically Necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a Physician or Psychologist licensed in this state and that will or is reasonably expected to:

  - prevent the onset of an illness, condition, Injury, or disability;
  - reduce or improve the physical, mental, or developmental effects of an illness, condition, Injury, or disability; or
  - assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.
- coverage for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist. Coverage must include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.
- charges made for treatment of Biologically-Based Mental Illness. Such Covered Expenses will be payable the same as for other illnesses. Any mental illness maximums in The

Schedule and any full payment area exceptions for mental illness will not apply to Biologically-Based Mental Illness.

Down Syndrome

Coverage for diagnosis and treatment of Down syndrome for a covered child 18 years of age or younger. Such coverage shall include habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed Physician, including but not limited to professional, counseling, and guidance services and treatment programs that are Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child; and Medically Necessary therapeutic care that is provided as follows:

- up to 104 sessions per year with a speech-language pathologist licensed pursuant to Title 37;
- up to 52 sessions per year with a physical therapist licensed pursuant to Title 37; and
- up to 52 sessions per year with an occupational therapist licensed pursuant to Title 37.

Habilitative and rehabilitative care includes Medically Necessary interactive therapies derived from evidence-based research, including intensive intervention programs and early intensive behavioral intervention. Benefits provided may not be construed as limiting physical health benefits that are otherwise available to the covered child.

When treatment is expected to require continued services, the insurer may request that the treating Physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is Medically Necessary. The treatment plan must be based on evidence-based screening criteria. The insurer may ask that the treatment plan be updated every 6 months.

As used in this section, "Medically Necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a Physician licensed in this state and that will or is reasonably expected to reduce or improve the physical, mental, or developmental effects of Down syndrome; or assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

Inborn Errors of Metabolism

Coverage for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist. Coverage must include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

Diabetes

The following benefits will apply to insulin and noninsulin-dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- charges for durable medical equipment, including podiatric appliances, related to diabetes. A special maximum will not apply.
- charges for insulin; syringes; injection aids, devises for self-monitoring of glucose levels (including those for the visually impaired), insulin pumps and accessories. Glucagon emergency kits, prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips; urine test strips; lancets; and alcohol swabs.
- charges for outpatient self-management training and education by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
  - Medically Necessary visits when diabetes is diagnosed;
  - visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
  - visits when reeducation or refresher training is prescribed by the Physician; and
  - medical nutrition therapy related to diabetes management.

Coverage for diabetes also includes screening for abnormal blood glucose as part of a cardiovascular risk assessment in adults aged 40-70 who are overweight or obese.

Home Health Care Services

Home Health Care Services are covered when skilled care is required under any of the following conditions:

- the required skilled care cannot be obtained in an outpatient facility;
- confinement in a Hospital or Other Health Care Facility is not required;
- the patient’s home is determined by Cigna to be the most medically appropriate place to receive specific services.

Covered services include:

- skilled nursing services provided by a Registered Nurse (RN); Licensed Practical Nurse (LPN); Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse (APRN).
- services provided by health care providers such as physical therapist; occupational therapist and speech therapist.
- nursing, home health aide services, physical therapy, occupational therapy, speech therapy, hospice service, medical supplies and equipment suitable for use in the home; and Medically Necessary personal hygiene, grooming, and dietary assistance.
- services of a home health aide when provided in direct support of those Nurses and health care providers.
- necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.

Note: Physical, occupational, and other Outpatient Therapy Services provided in the home are covered under the Outpatient Therapy Services benefit shown in The Schedule.

The following are excluded from coverage:

- services provided by a person who is a member of the patient's family, even when that person is a health care provider.
- services provided by a person who normally resides in the patient's house, even when that person is a health care provider.
- non-skilled care, Custodial Services, and assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other services; self-care activities; homemaker services; and services primarily for rest, domiciliary or convalescent care.

Home Health Care Services, for a patient who is dependent upon others for non-skilled care and/or Custodial Services, is provided only when there is a family member or caregiver present in the home at the time of the health care visit to provide the non-skilled care and/or Custodial Services.

Mental Health and Substance Use Disorder Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Use Disorder.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Services are exchanged with Inpatient Mental Health Services at a rate of two days of Mental Health Residential Treatment being equal to one day of Inpatient Mental Health Treatment.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Partial Hospitalization or Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; autism spectrum disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment and Applied Behavior Analysis (ABA).

Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program in accordance with the laws of the appropriate, legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Use Disorder Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Residential Treatment services.

Substance Use Disorder Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Use Disorder conditions.

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorder Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, a group, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program.

Substance Use Disorder Partial Hospitalization services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Use Disorder Intensive Outpatient Therapy Program services are exchanged with Outpatient Substance Use Disorder services at a rate of one visit of Substance Use Disorder Intensive Outpatient Therapy being equal to one visit of Outpatient Substance Use Disorder Rehabilitation Services.

Substance Use Disorder Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- geriatric day care, occupational and recreational therapy for age related cognitive decline.
- special education, including but not limited to school tuition.
- counseling for educational reasons, IQ testing or other testing (including psychological testing on children requested by or for a school system).
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious training and counseling.
- cognitive rehabilitation.
- work-hardening programs.
- wilderness programs.
- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for borderline intellectual functioning.

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was

performed; surgical services for reconstruction of the other breast to produce symmetrical appearance; and mastectomy bras and prosthetics, limited to the lowest cost alternative available that meets prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

- charges for Medically Necessary inpatient Hospital care following a mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer. The period of time for the hospitalization is to be determined by the Physician in consultation with the patient.

HC-COV601 10-16
ET

Transplant Services and Related Specialty Care

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.

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. Implantation procedures for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO), ventricular assist device (VAD), and intra-aortic balloon pump (IABP) are also covered.

Transplant services and related specialty care received at any other facilities, including non-Participating Provider facilities and Participating Provider facilities not specifically contracted with Cigna for Transplant services and related specialty care services, are covered at the Out-of-Network level.

- Cornea transplants received at a facility that is specifically contracted with Cigna for this type of transplant are payable at the In-Network level.

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 hospitalization, and surgery necessary for removal of an organ and transportation of a live donor (refer to Transplant and Related Specialty Care Travel Services). 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.

Advanced cellular therapy, including but not limited to, immune effector cell therapies and Chimeric Antigen Receptor Therapy (CAR-T) cellular therapy, is covered when performed at a Cigna LifeSOURCE Transplant Network® facility with an approved stem cell transplant program. Advanced cellular therapy received at Participating Provider facilities specifically contracted with Cigna for advanced cellular therapy, other than Cigna LifeSOURCE Transplant Network® facilities, are payable at the In-Network level. Advanced cellular therapy received at any other facility, including non-Participating Provider facilities and Participating Provider facilities not specifically contracted with Cigna for advanced cellular therapy, are covered at the Out-of-Network level.

Transplant and Related Specialty Care Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations:

- Transplant and related specialty care travel benefits are not available for cornea transplants.
- Benefits for transportation and lodging are available to the recipient of a pre-approved organ/tissue transplant and/or related specialty care from a designated Cigna LifeSOURCE Transplant Network® facility.
- Benefits for transportation and lodging are available to the recipient of a pre-approved organ/tissue transplant and/or related specialty care.
- The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care.
- Travel expenses for the person receiving the transplant will include charges for: transportation to and from the designated Cigna LifeSOURCE Transplant Network® facility (including charges for a rental car used during a period of care at the Cigna designated LifeSOURCE Transplant Network® facility); and lodging while at, or traveling to and from the Cigna LifeSOURCE Transplant Network® facility.
- 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 who is at least 18 years of age.
- The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income; travel costs incurred due to travel within 60 miles of your home;

food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits for Transplant Services and Related Specialty Care, and for Transplant and Related Specialty Care Travel Services are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant; the transplant recipient's plan would cover all donor costs.

HC-COV1163 01-21
ET

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that are administered in an inpatient setting, outpatient setting, Physician's office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling. The following diabetic supplies are also covered under the plan's medical benefit: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (including one insulin pump for each warranty period), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug Product first.

Utilization management requirements or other coverage conditions are based on a number of factors which may include clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

HC-COV1141 01-21
ET

Clinical Trials

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate; or
- the individual provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered.

The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that meets **any** of the following criteria:

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Health Care Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);

- a qualified non-governmental research entity identified in NIH guidelines for center support grants.
- any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:
  - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
  - the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA);
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The plan does not cover any of the following services associated with a clinical trial:

- services that are not considered routine patient care costs and services, including the following:
  - the investigational drug, device, item, or service that is provided solely to satisfy data collection and analysis needs;
  - an item or service that is not used in the direct clinical management of the individual;
  - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- an item or service provided by the research sponsors free of charge for any person enrolled in the trial.
- travel and transportation expenses, unless otherwise covered under the plan, including but not limited to the following:
  - fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train;
  - mileage reimbursement for driving a personal vehicle;
  - lodging;
  - meals.
- routine patient costs obtained out-of-network when Out-of-Network benefits do not exist under the plan.

Examples of routine patient care costs and services include:

- radiological services.
- laboratory services.
- intravenous therapy.
- anesthesia services.
- Physician services.
- office services.
- Hospital services.
- Room and Board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

Clinical trials conducted by Out-of-Network providers will be covered only when the following conditions are met:

- In-Network providers are not participating in the clinical trial; or
- the clinical trial is conducted outside the individual’s state of residence.

HC-COV1016 01-21
ET

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by Cigna only to a person who:

- resides in a state that requires offering a conversion policy,
- is Entitled to Convert, and
- applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled to Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased but only if:

- you are not eligible for other individual insurance coverage on a guaranteed issue basis.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.

- your insurance did not cease because the policy in its entirety canceled.

If you retire, you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for other individual insurance coverage on a guaranteed issue basis, is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy

If you reside in a state that requires the offering of a conversion policy, the Converted Policy will be one of Cigna's current conversion policy offerings available in the state where you reside, as determined based upon Cigna's rules.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are Entitled to Convert, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

HC-CNV28 05-14
V2-ET

Payment of Benefits

Assignment and Payment of Benefits

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

You may, however, authorize Cigna to pay any healthcare benefits under this policy to a Participating or non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider’s responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Expenses directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the non-Participating Provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

- **(1)** Except as provided in subsection (3), (4), or (5), if a health insurance issuer limits the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer has the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim.
- **(2)** Except as provided in subsection (3), (4), or (5), if a health insurance issuer does not limit the time in which a health care provider or other person is required to submit a claim for payment, a health insurance issuer may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than 12 months after the payment of an invalid or overpaid claim.
- **(3)** Regardless of the period allowed by a health insurance issuer for submission of claims for payment, a health insurance issuer may perform a review or audit to reconsider the validity of a claim and may request reimbursement for an invalid or overpaid claim within 12 months from the date upon which the health insurance issuer received notice of a determination, adjustment, or agreement regarding the amount payable with respect to a claim by:
  - **(a)** Medicare;
  - **(b)** a workers' compensation insurer;
  - **(c)** another health insurance issuer or group health plan;
  - **(d)** a liable or potentially liable third party; or
  - **(e)** a foreign health insurance issuer under an agreement among plans operating in different states when the agreement provides for payment by the Montana health insurance issuer as host plan to Montana providers for services provided to an individual under a plan issued outside of the state of Montana.
- **(4)**
  - **(a)** The time limitations on the health insurance issuer in subsections (1) and (2) do not commence running until the time specified in subsection (4)(b) if a health insurance issuer pays a claim in which the health insurance issuer:
    - **(i)** suspects the health care provider or claimant of insurance fraud related to the claim; and
    - **(ii)** has reported evidence of fraud related to the claim to the commissioner pursuant to 33-1-1205.
  - **(b)** The time limitation commences running on the date that the commissioner determines that insufficient evidence of fraud exists.
- **(5)** The time limitations on the health insurance issuer in subsections (1) and (2) do not commence running until the health insurance issuer has actual knowledge of an invalid claim, claim overpayment, or other incorrect payment if the health insurance issuer has paid a claim incorrectly because of an error, misstatement, misrepresentation, omission, or concealment, other than insurance fraud, by the health care provider or other person. Regardless of the date upon which the health insurance issuer obtains actual knowledge of an invalid claim, claim overpayment, or other incorrect payment, this subsection does not permit the health insurance issuer to request reimbursement or to offset another claim payment for reimbursement of the claim more than 24 months after payment of the claim.

A health insurance issuer may not collect a claim overpayment or other reimbursement by offsetting another claim payment made to a health care provider or other person unless the health care provider or other person has previously authorized the health insurance issuer in writing to recover an overpayment or other reimbursement by offsetting a future claim payment.

Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the current procedural terminology.

- the methodologies as reported by generally recognized professionals or publications.

HC-POB155 01-19
ET

Termination of Insurance

Reduction in Work Schedule (for Medical Insurance)

If your insurance would otherwise cease due to a reduction of the number of hours in your regular work schedule, your insurance may be continued subject to all the other terms and conditions of the policy as long as you continue to be employed. Your insurance will not be continued past the date your Employer stops paying premium for you or otherwise cancels your insurance. Medical Insurance will not be continued for more than one year.

HC-TRM1 04-10
V4-ET

Definitions

Biologically-Based Mental Illness

A Biologically-Based Mental Illness is any of the following disorders, as defined by the American Psychiatric Association: schizophrenia; schizoaffective disorder; bipolar disorder; major depression; panic disorder; obsessive-compulsive disorder; and autism.

HC-DFS587 04-10
V1-ET

Dependent

Covered children include:

- a child from the moment of birth. Newborns are covered for 31 days before additional premiums, if any, are due.
- a legally adopted child including coverage from the date of preadoptive placement in your home.
- a child of your insured Dependent until the date your insured Dependent is no longer eligible for coverage.

Pre-existing coverage limitations and waiting periods do not apply to newborns or newly adopted children. Deductibles apply to newly acquired children only to the extent they apply to any other insured person.

HC-DFS414 01-11
V11-ET

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

CERTIFICATE RIDER – Nevada Residents

Rider Eligibility: Each Employee who is located in Nevada

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Nevada group insurance plans covering insureds located in Nevada. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNVRDR

Important Notices

Nevada Division of Insurance

You can contact the Nevada Division of Insurance at the following:

The Department of Business Industry, Division of Insurance

Toll free number: (888) 872-3234

Hours of operation of the division: Mondays through Fridays from 8:00 a.m. until 5:00 p.m., Pacific Standard Time (PST).

If you have local telephone access to the Carson City and Las Vegas offices of the Division of Insurance, you should call the local numbers.

Local telephone numbers are: Carson City, **702-687-4270** and Las Vegas, **702-486-4009**

HC-IMP48 04-10
V2-ET

Covered Expenses

- charges for a drug that has been prescribed for the treatment of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration if that drug has been recognized as a treatment for cancer by either the American Hospital Formulary Services Drug Information; US Pharmacopoeia Drug Information; or supported by at least two articles published in accepted scientific medical journals. Coverage will also be provided for any medical services necessary to administer the drug.

HC-COV1225 01-22
ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” sections of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. The plan or policy shall not deny, for treatment of cancer, coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of cancer the prescribed indication in the American Hospital Formulary Services Drug information; US Pharmacopoeia Drug Information; or supported by at least two articles published in accepted scientific medical journals.

HC-EXC481 01-22
ET

Definitions

If Domestic Partners are covered under the plan, then the following applies:

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

HC-DFS709 01-15
ET

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

CERTIFICATE RIDER – New Hampshire Residents

Rider Eligibility: Each Employee who is located in New Hampshire

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of New Hampshire group insurance plans covering insureds located in New Hampshire. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNHRDR

Notice

This certificate, issued in New Hampshire, is under the jurisdiction of the New Hampshire Commissioner of Insurance, and is governed by New Hampshire law.

HC-IMP111 04-10

V1-ET

New Hampshire Patient Bill of Rights

The following information is being provided to you pursuant to 415:18-XIV and 415:6-f. These statutes require any insurer issuing a group or individual policy to provide each new certificate holder or policy holder with the following information. When admitted to a facility (except those admitted by a home health care provider):

I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.

II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.

IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph “health care provider” means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.

V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.

VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with

the patient's rights under this subdivision and in conformance with state law and rules.

VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

XVI. The patient shall not be denied appropriate care on the basis of age, sex, gender identity, sexual orientation, race, color, marital status, familial status, disability, religion, national origin, source of income, source of payment, or profession.

XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, unmarried partner or a personal representative chosen by the patient, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.

XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.

XX. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.

XXI. Subject to the terms and conditions of the patient’s insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

XXII. The patient shall not be denied admission, care, or services based solely on the patient's vaccination status.

XXIII. (a) In addition to the rights specified in paragraph XVIII, the patient shall be entitled to designate a spouse, family member, or caregiver who may visit the facility while the patient is receiving care. A patient who is a minor may have a parent, guardian, or person standing in loco parentis visit the facility while the minor patient is receiving care.

(b)(1) Notwithstanding subparagraph (a), a health care facility may establish visitation policies that limit or restrict visitation when:

(A) The presence of visitors would be medically or therapeutically contraindicated in the best clinical judgment of health care professionals;

(B) The presence of visitors would interfere with the care of or rights of any patient;

(C) Visitors are engaging in disruptive, threatening, or violent behavior toward any staff member, patient, or another visitor; or

(D) Visitors are noncompliant with written hospital policy.

(2) Upon request, the patient or patient's representative, if the patient is incapacitated, shall be provided the reason for denial or revocation of visitation rights under this paragraph.

(c) A health care facility may require visitors to wear personal protective equipment provided by the facility, or provided by the visitor and approved by the facility. A health care facility may require visitors to comply with reasonable safety protocols and rules of conduct. The health care facility may revoke visitation rights for failure to comply with this subparagraph.

(d) Nothing in this paragraph shall be construed to require a health care facility to allow a visitor to enter an operating room, isolation room, isolation unit, behavioral health setting or other typically restricted area or to remain present during the administration of emergency care in critical situations. Nothing in this paragraph shall be construed to require a health care facility to allow a visitor access beyond the rooms, units, or wards in which the patient is receiving care or beyond general common areas in the health care facility.

(e) The rights specified in this paragraph shall not be terminated, suspended, or waived by the health care facility, the department of health and human services, or any governmental entity, notwithstanding declarations of emergency declared by the governor or the legislature. No health care facility licensed pursuant to RSA 151:2 shall require a patient to waive the rights specified in this paragraph.

(f) Each health care facility licensed pursuant to RSA 151:2 shall post on its website:

(1) Informational materials explaining the rights specified in this paragraph;

(2) The patients' bill of rights which applies to the facility on its website; and

(3) Hospital visitation policy detailing the rights and responsibilities specified in this paragraph, and the limitations placed upon those rights by written hospital policy on its website.

(g) Unless expressly required by federal law or regulation, the department or any other state agency shall not take any action arising out of this paragraph against a health care facility for:

(1) Giving a visitor individual access to a property or location controlled by the health care facility;

(2) Failing to protect or otherwise ensure the safety or comfort of a visitor given access to a property or location controlled by the health care facility;

(3) The acts or omissions of any visitor who is given access to a property or location controlled by the health care facility.

HC-IMP333 01-23
ET

Eligibility - Effective Date

Late Entrant - Employee

You are a Late Entrant if you elect the insurance more than 31 days after you become eligible.

Dependent Insurance

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if you elect that insurance more than 31 days after you become eligible for it.

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth and continue for 31 days. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Exception for Newborn Grandchildren

Any child born to your Dependent child while you are insured will be covered for the first 31 days of his life. Coverage for such child will not continue beyond the 31st day and no benefits for expenses incurred beyond the 31st day will be payable.

HC-ELG361 01-23
ET1

Certification Requirements – Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Covered Expenses incurred will be reduced by the lesser of 50% or $1,000 for Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission.

- unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will be reduced by the lesser of 50% or $1,000:

- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Certification Requirements – Out-of-Network

Covered Expenses incurred will be reduced by the lesser of 50% or $1,000 for charges made for any outpatient diagnostic testing or outpatient procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

HC-PAC119 01-20
ET

Prior Authorization/Pre-Authorized

- non-emergency Ambulance excluding Medically Necessary interfacility transports for services related to treatment and diagnosis of biologically-based mental illnesses.

HC-PRA58 10-22
V1 ET

The Schedule

The Medical Schedule is amended to indicate that no separate maximum/deductible shall apply to **Diabetic Equipment**.

The **Nutritional Evaluation** annual maximum shown in the Medical Schedule is amended to indicate the following:

“3 visits per person however, the 3 visit limit will not apply to treatment of diabetes.”

SCHEDDENE-ET1

Covered Expenses

- charges for cancer screening blood tests; Perfluoroalkyls (PFAS) and Perfluorinated Compound (PFC).
- coverage for long-term antibiotic therapy for tick-borne illness when determined to be Medically Necessary and ordered by a licensed infectious disease Physician after making a thorough evaluation of the patient’s symptoms, diagnostic test results or response to treatment.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges for all necessary medical examinations, imaging studies, and tests required to make a gestational age determination prior to an abortion.
- charges made for treatment of the diseases and ailments caused by obesity and morbid obesity, including bariatric surgery. The insured’s prescribing Physician must issue a written order stating that treatment is Medically Necessary and in accordance with the patient qualifications and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. The covered insured must be at least 18 years of age.

- charges made for the professional services associated with the practice of fitting, dispensing, service or sale of hearing instruments or hearing aids by a hearing instrument dispenser or other hearing care professional. Coverage includes the cost of a hearing aid for each ear, as needed, as well as related services necessary to assess, select, and fit the hearing aid. An insured person may choose a higher-priced hearing aid, and pay the difference in the cost. Hearing aids must be described and dispensed by a licensed audiologist or hearing instrument specialist.
- charges for or in connection with mammograms for breast cancer screening or diagnostic purposes not to exceed: one baseline low-dose mammogram, including 3-D tomosynthesis mammography for women ages 35 to 39 years of age; a mammogram every one to two years for women 40 to 49 years of age, even if no symptoms are present; and one annual mammogram for women age 50 and over.
- charges for the treatment of cancer by autologous bone marrow transplants, which follows the protocols reviewed and approved by the National Cancer Institute.
- charges for laboratory fee expenses arising from human leukocyte antigen testing (also referred to as histocompatibility locus antigen testing) for utilization in bone marrow transplantation, up to $150. The testing facility may not bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a covered person or a person acting on behalf of a covered person for any portion of the laboratory fee expenses.
- charges for 48 hours inpatient stay following a vaginal delivery or 96 hours following a cesarean section. An earlier discharge may be determined by the mother and attending Physician. An additional length of stay will be covered if deemed Medically Necessary.

  If discharge is prior to the 48/96 hours, at least 2 postpartum visits will be provided if the service is by a licensed Physician with experience in perinatal care. Postpartum visits shall include a physical assessment of mother and infant. The assessment shall include but not be limited to: infant nutrition and feeding, infant behavior, family interactions, safety and injury prevention, infant and maternal health promotion, and community resources. Providers of postpartum visits shall be licensed health care providers experienced in perinatal care.
- charges for Medically Necessary prenatal and/or postpartum homemaker services when a woman is confined to bed rest or her daily activities are restricted by her provider.
- charges being provided in a licensed health care facility or at home and within the scope of practice of a certified midwife.
- charges made by a Hospital or an Ambulatory Surgical Facility for general anesthesia administered by a licensed anesthesiologist or anesthetist for dental procedures for: a child under the age of 13 who is determined by a licensed dentist in conjunction with a licensed Physician to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in an Ambulatory Surgical Facility or Hospital setting; or an individual with a developmental disability or exceptional medical circumstances, as determined by a licensed Physician, which place the person at serious risk.
- charges made for treatment of Biologically-Based Mental Illness, including: schizophrenia and other psychotic disorders; schizoaffective disorder; major depressive disorder; bipolar disorder; anorexia nervosa and bulimia nervosa; obsessive-compulsive disorder including pediatric autoimmune neuropsychiatric disorders, when treatment, including the use of intravenous immunoglobulin therapy; panic disorder; pervasive developmental disorder or autism; or chronic post-traumatic stress disorder. Such Covered Expenses will be payable the same as for other illnesses. Any exceptions or limitations for mental illness shown in The Schedule will not apply to Biologically-Based Mental Illness.
- charges for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with children from birth to age 3 with an identified developmental disability and/or delay as long as the providing therapist receives a referral from the child's Primary Care Physician, if applicable.
- charges for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia including the treatment of breast cancer by autologous bone marrow transplants, or permanent loss of scalp hair due to injury, upon written recommendation of a Physician. Scalp hair prostheses means artificial substitutes for scalp hair that are made for a specific individual.
- charges for Medically Necessary services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists and clinical social workers provided to a child with an identified developmental disability and/or delay, as long as the providing therapist receives a referral from the child’s Primary Care Physician, if the plan requires such referral.

The following benefits will apply to insulin and non-insulin-dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- charges for Durable Medical Equipment, including podiatric appliances, related to diabetes. A special maximum will not apply.
- charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
  - Medically Necessary visits when diabetes is diagnosed;
  - visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
  - visits when reeducation or refresher training is prescribed by the Physician; and
  - medical nutrition therapy related to diabetes management.
- charges made for telemedicine services to the same extent that such services are available for other conditions covered under the plan.

  Telemedicine means the use of audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. It does not include facsimile.

Coverage includes nonprescription enteral formulas and food products for the treatment of impaired absorption of nutrients caused by disorders of the gastrointestinal tract or inherited diseases of amino or organic acids. The Physician must issue a written order stating the enteral formula or food product is needed to sustain life, in the case of malabsorption, medically necessary, and the least restrictive and most cost-effective means for meeting the needs of the insured. Coverage for inherited diseases of amino and organic acids will, in addition to the enteral formula, include food products modified to be low protein in an amount not to exceed $1,800 annually for any covered individual.

For other diagnosis not specified above, coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism (e.g. disorders of amino acid or organic acid metabolism).

Covered Expenses

Mental Health and Substance Use Disorder Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes.

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination

of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Use Disorder Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Partial Hospitalization sessions and Residential Treatment services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Substance Use Disorder Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Use Disorder conditions.

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorder Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Use Disorder Intensive Outpatient Therapy Program.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Use Disorder Partial Hospitalization services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

Substance Use Disorder Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician; cryopreservation, storage, and thawing of sperm, eggs and embryos; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and the services of an embryologist.

Infertility is defined as:

- the inability of opposite sex partners to achieve conception after at least one year of unprotected intercourse;
- the inability of opposite sex partners to achieve conception after six months of unprotected intercourse, when the female partner trying to conceive is age 35 or older;
- the inability of a woman, with or without an opposite sex partner, to achieve conception after at least six trials of

medically supervised artificial insemination over a one-year period; and
- the inability of a woman, with or without an opposite sex partner, to achieve conception after at least three trials of medically supervised artificial insemination over a six-month period of time, when the female partner trying to conceive is age 35 or older.

This benefit includes diagnosis and treatment of both male and female infertility and male and female fertility preservation.

However, the following are specifically excluded infertility services:
- reversal of male and female voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges and services; and
- any experimental, investigational or unproven infertility procedures or therapies.

Clinical Trials

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:
- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate; or
- the individual provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered.

The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that meets **any** of the following criteria:
- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Health Care Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
  - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
- any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:
  - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
  - the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA);
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The plan does not cover any of the following services associated with a clinical trial:
- services that are not considered routine patient care costs and services, including the following:
  - the investigational drug, device, item, or service that is provided solely to satisfy data collection and analysis needs;
  - an item or service that is not used in the direct clinical management of the individual;
  - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- an item or service provided by the research sponsors free of charge for any person enrolled in the trial.
- travel and transportation expenses, unless otherwise covered under the plan, including but not limited to the following:
  - fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train;
  - mileage reimbursement for driving a personal vehicle;
  - lodging;
  - meals.
- routine patient costs obtained out-of-network when Out-of-Network benefits do not exist under the plan.

Examples of routine patient care costs and services include:
- radiological services.
- laboratory services.
- intravenous therapy.

- anesthesia services.
- Physician services.
- office services.
- Hospital services.
- Room and Board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

Clinical trials conducted by Out-of-Network providers will be covered only when the following conditions are met:

- In-Network providers are not participating in the clinical trial; or
- the clinical trial is conducted outside the individual's state of residence.

HC-COV1016 01-21
ET

The Schedule

The pharmacy schedule is amended to add the following:

Oral Chemotherapy Medication

Prescription oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered at Participating Pharmacies at 100% after deductible and if applicable at Non-Participating Pharmacies, the same as the out of network medical cost share for injectable/IV chemotherapy. Any member cost share will not exceed $200 per prescription.

SCHEDPHARM90-nhet

Prescription Drug Benefits

Limitations

Prior Authorization Requirements

If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If coverage for a non-formulary prescription drug is denied and your medical condition is such that waiting for the standard appeal process to be completed would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you may be eligible for an expedited review. We will complete expedited reviews within 48 hours of receiving clinical rationale for the exception from the prescribing Physician. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the Prescription Drug Product should be covered. If you have questions about a specific Prescription Drugs List exception or prior authorization request, you should call Member Services at the toll-free number on the ID card.

Supply Limits

Coverage will be provided for a refill of any Prescription Drug Product prescribed for the treatment of a chronic illness, if the refill is scheduled to synchronize with your other/multiple Prescription Drug Product refills in accordance with a plan made between you, your health care practitioner and the pharmacist.

Covered persons may obtain an emergency prescription for up to a 72-hour supply of covered prescription drugs on the health benefit plan formulary. This also includes prescription drugs that have been deleted from the health benefit plan formulary within the last 90-days and requires an exception and the exception has neither been approved nor denied and a pharmacist has determined the medication is essential to the maintenance of life or to the continuation of therapy in a chronic condition, or the interruption of therapy might reasonably produce undesirable health consequences or may cause physical or mental discomfort.

For prescription eye drops, an early refill will be allowed when:

- For prescription eye drops dispensed as a 30-day supply, the enrollee requests the refill no earlier than 21 days after the later of the following dates:
  - The date the original prescription was dispensed to the enrollee; or
  - The date that the most recent refill of the prescription was dispensed to the enrollee.
- For prescription eye drops dispensed as a 90-day supply, the enrollee requests the refill no earlier than 63 days after the later of the following dates:
  - The date the original prescription was dispensed to the enrollee; or
  - The date that the most recent refill of the prescription was dispensed to the enrollee;
- The prescribing health care provider indicated on the original prescription that a specific number of refills are authorized;
- The refill requested by the enrollee does not exceed the number of refills indicated on the original prescription;
- The prescription has not been refilled more than once during the 90-day or 90-day period prior to the request for an early refill; and
- The prescription eye drops are a covered benefit under the enrollee's health plan.

Hormonal Contraceptive Drugs

A pharmacist will be allowed to dispense Hormonal Contraceptive Drugs based on a standing order written by a Physician or advanced practice registered nurse. An initial screening performed by a pharmacist for a standing order for Hormonal Contraceptive Drugs is covered. Coverage includes reimbursement for contraceptives prescribed for up to a 12-month period. There is no coverage for more than one 12-month contraceptive prescription in a single plan year. A 12-month prescription for a contraceptive drug is not subject to utilization review requirements or other limitations to control the prescribing or dispensing of contraceptives to an amount that is less than a 12-month supply. When a therapeutic equivalent of a drug or device for an FDA-approved contraceptive method is available, a cost-share may apply as long as at least one drug or device for that method is available without cost-sharing. If your provider recommends a particular FDA-approved contraceptive drug or device based on a medical determination, coverage for that prescribed contraceptive drug or device is available without cost-sharing.

Hormonal Contraceptive Drugs means pills, patches, and rings which the United States Food and Drug Administration (FDA) classifies as available by prescription for the purpose of contraception or emergency contraception. It does not include similar items classified as over the counter by the FDA, intrauterine devices, shots, or intradermal implants.

Outpatient contraceptive services means consultations, examinations, and medical services, provided on an outpatient basis, including the initial screening, provided through a pharmacy at a rate established by contract between the pharmacy and your provider or its pharmacy benefits manager, and related to the use of contraceptive methods to prevent pregnancy which has been approved by the U.S. Food and Drug Administration.

Standing order means a written and signed protocol authored by one or more Physicians or one or more advanced practice registered nurses licensed in this state. This agreement must specify a protocol allowing the pharmacist to dispense Hormonal Contraceptives under the delegated prescriptive authority of the Physician or APRN, specify a mechanism to document screening performed and the prescription your medical record, and include a plan for evaluating and treating adverse events. This prescription must be regarded as being issued for a legitimate medical purpose in the usual course of professional practice.

Medication Synchronization

Medication synchronization refers to the coordination of medication refills for a patient taking two or more medications for a chronic, long-term condition such that the patient's medications are refilled on the same schedule for a given time period.

If you or your Dependent requests medication synchronization for a new prescription, your prescription may be filled as follows:

- For less than a 30-day supply of the Prescription Drug Product;
- A synchronization must only occur once per year per maintenance-prescription drug.

Upon your request, the prescribing provider or pharmacist shall:

- Determine that filling or refilling the prescription is in your best interest, taking into account the appropriateness of synchronization for the drug being dispensed.

Prescription drug coverage shall provide for medication synchronization for an insured if all of the following conditions are met: 1) the insurer must apply a prorated, daily cost-sharing rate to covered prescriptions dispensed by an In-Network pharmacy; 2) the insurer must not reimburse or pay any dispensing fee that is prorated. The insurer must only pay or reimburse a dispensing fee that is based on each maintenance-prescription drug dispensed.

To be eligible a drug must: 1) be covered by the policy, certificate, or contract; 2) have authorized refills that remain available to the customer; 3) meet all utilization management requirements specific to the maintenance-prescription drugs that are being requested to be synchronized; 4) be effectively split over required short-fill periods to achieve synchronization; 5) not be a controlled substance included in schedules II-V; 6) not have quantity limits or dose-optimization criteria or requirements that will be violated by synchronizing the medications.

Coverage will be provided for epinephrine auto-injectors at the same cost share, subject to the same requirements, as any other similar benefit.

HC-PHR612 01-23
ET

Prescription Drug Benefits

Exclusions

- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was

previously excluded under this provision may be reinstated at any time.

- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
- medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions unless specifically identified on the Prescription Drug List.

HC-PHR598 01-23
ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

  The plan or policy shall not deny coverage for a drug therapy or device as experimental, investigational and unproven if the drug therapy or device is otherwise approved by the FDA to be lawfully marketed and is recognized for treatment of the prescribed indication in one of the standard reference compendia or in the medical literature.
- the following services are excluded, unless Medically Necessary: macromastia (abnormal largeness of a woman's breasts) or surgeries for gynecomastia (abnormal enlargement of a man's breasts); surgical treatment of varicose veins (enlarged veins that are swollen and raised above the surface of the skin); abdominoplasty (plastic surgery of the abdomen in which excess fatty tissue and skin are removed, usually for cosmetic purposes); panniculectomy (surgical excision of the abdominal apron of superficial fat in the obese); rhinoplasty (plastic surgery of the nose); blepharoplasty (plastic surgery of the eyelids).
- surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) except for Medically Necessary orthognathic surgery and craniofacial muscle disorders.
- The court-order exclusion does not apply to court-ordered services for minors. Benefits for such court-ordered services shall be subject to the same dollar limits, Deductibles, Copayments and Coinsurance factors and to the terms and conditions of the policy and certificate, including any managed care provisions. However, the claimant or claimant's representative shall have 48 hours from the commencement of a court-ordered, services, placement, or program to seek any pre-authorization, pre-certification, or referral required under the terms of the policy.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs. (See the Covered Expenses section of this certificate for information regarding coverage of scalp hair prostheses.)

HC-EXC514 01-23
ET

Payment of Benefits

Assignment and Payment of Benefits

Medically Necessary Ambulance services will be reimbursed to the Ambulance service provider directly or by a check payable to you and the Ambulance service provider, subject to the conditions of the policy, plan, or contract.

HC-POB176 01-23
ET

Continuation of Coverage Under New Hampshire State Law

Continuation of Medical Insurance – Employee

If you or your Dependent's insurance would otherwise cease because of termination of employment, for reasons other than gross misconduct or carrier termination, your Medical insurance will be continued for up to 18 months upon payment of the required premium by you to your Employer. It will continue until the earliest of:

- 18 months from the date your work hours are reduced or your employment terminates;
- the last day of the period for which you have paid the required premium;
- the date you or your Dependent becomes entitled to Medicare;
- the date you or your Dependent becomes eligible for insurance under another group policy for medical benefits;
- the date the policy is canceled;
- the date a Dependent ceases to qualify as a Dependent.

Continuation of Medical Insurance –– Disabled Individuals

If you are or your Dependent is disabled within 60 days of the date of termination of employment, you may continue health insurance for up to an additional 11 months beyond the 18 month period. To be eligible you or your Dependent must:

- be declared disabled under Title II or XVI by the Social Security Administration; and
- notify the plan administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the plan administrator with a copy of the determination.

Continuation of Medical Insurance – Former Spouse

A covered former spouse is entitled to continue coverage following a final decree of divorce or legal separation, until the earliest of the following:

- the date you are no longer insured under the group policy for any reason (including the date of your death);
- the three-year anniversary of the final decree of divorce or legal separation;
- the date your former spouse remarries;
- the date you remarry;
- the date the court decree no longer requires continued coverage.

If coverage for a former spouse ends under this continuation provision for any of the reasons described, he or she is eligible to obtain up to an additional 36 months of continuation under the provision **Continuation of Medical Insurance - Dependent**.

Continuation of Medical Insurance –– Dependent

If Medical insurance for your Dependents would otherwise cease because of: (1) your death; (2) your entitlement to Medicare; (3) divorce or legal separation; or (4) with respect to a Dependent child, failure to continue to qualify as a Dependent, Medical insurance may be continued upon payment of the required premium to the Employer. It will continue until the earliest of:

For a Dependent child:

- 36 months from the date of (1), (2), (3) or (4) above or when coverage reduction or termination takes place within one year of the date the Employer files for protection under the bankruptcy provisions of Title 11 of the United States Code, whichever may occur first;
- the last day for which the required premium has been paid;
- the date the Dependent child ceases to be a Dependent child;
- the date the Dependent becomes entitled to Medicare;
- the date the Dependent becomes covered under another group health plan;
- the date the policy is canceled.

For a spouse who is under age 55:

- 36 months from the date of (1), (2), (3) or (4) above or when coverage reduction or termination takes place within one year of the date the Employer files for protection under the bankruptcy provisions of Title 11 of the United States Code, whichever may occur first;
- the last day for which the required premium has been paid;
- the date the Dependent becomes entitled to Medicare;

- the date the Dependent becomes covered under another group health plan;
- the date the policy is canceled.

For a spouse who is age 55 or over:

- the date your former spouse becomes eligible for coverage under another group health plan;
- the date your former spouse becomes eligible for Medicare;
- the last day for which the required premium has been paid;
- the date the policy is canceled.

Notification and Election

Cigna will notify you (or in the case of divorce or legal separation, your former spouse) of the right to continue coverage within 30 days after receiving notice regarding loss of coverage. You and your Dependents (or in the case of divorce or legal separation, your former spouse) must submit an application and first premium payment no later than 45 days after notice of the right to continue coverage was sent.

Continuation of Medical Insurance – Group Plan Termination

If group medical coverage for you or your Dependents is canceled because the group plan terminates, coverage may be continued from the date of cancellation until the earliest of the following:

- 39 weeks from the date group coverage is canceled;
- the date the person fails to make a timely premium payment;
- the date the person becomes eligible for benefits under another group plan or under Medicare; or
- the date your Dependent ceases to qualify as a Dependent under the provisions of the plan.

Notification and Election

If the group plan terminates because of nonpayment of group premium, Cigna will notify you of your right to continue coverage within 30 days after the termination date. Termination of the group plan for nonpayment of premium will not occur before the expiration of any required grace period for premium payment.

You and/or your Dependents shall provide written notice of election together with the required premium within 31 days of the date of the notice.

If coverage for you and your Dependents ends because Cigna does not provide required notice of continuation, Cigna will be liable for any benefits payable during the lapse in coverage.

Special Continuation of Medical Insurance - Strike

If your Active Service ends due to strike, your insurance will be continued until the earliest of:

- 6 months past the date your Active Service ends;
- the date you fail to make a timely premium payment; or
- the date you become eligible for insurance under another group policy for medical benefits or Medicare.

Medical benefits only may be continued for an additional 12 months in accordance with federal law.

HC-TRM180 08-22

V1-ET

Medical Benefits Extension Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you are or your Dependent is Totally Disabled on that date due to an Injury or Sickness, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group policy;
- the date you are no longer Totally Disabled;
- 12 months from the date your Medical Benefits cease; or
- 12 months from the date the policy is canceled.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

Except as shown in the Exception for Newborns section of this certificate, the terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when you or your Dependent's Medical Benefits cease.

HC-BEX29 04-10
V1-ET

Definitions

Dependent

Dependents include:

- your lawful spouse of the same or opposite sex.

A child includes a legally adopted child, including that child from the first day of placement in your home. However, if your petition of adoption is withdrawn or dismissed, coverage for the child will be terminated.

A Dependent child shall include a subscriber's child by blood or by law, who is under age 26.

HC-DFS1731 01-23
ET

Dependent – Applies to Vision Only

Dependents include:

- your lawful spouse (including a partner to a civil union); or
- any child of yours who is
  - less than 26 years old.

A child includes a child born to you or a legally adopted child, including that child from the first day of placement in your home. However, if your petition of adoption is withdrawn or dismissed, coverage from the child will be terminated.

HC-DFS298 04-10
V1-ET

Emergency Medical Condition

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

HC-DFS1750 01-23
ET

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner, including certified midwives, whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

HC-DFS258 04-10
V1-ET

Primary Care Physician

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice, pediatrics or naturopathic medicine; and who has been voluntarily selected by you and is contracted as a Primary Care Physician with, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

HC-DFS1753 01-23
ET

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

CERTIFICATE RIDER – New York Residents

Rider Eligibility: Each Employee who is located in New York

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of New York group insurance plans covering insureds located in New York. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNYRDR

SECTION X. Additional Benefits, Equipment and Devices

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Enteral Nutrition

Are medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism (e.g. disorders of amino acid or organic acid metabolism).

SECTION XI. Inpatient Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. End of Life Care.

If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited external appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

HC-COV1251 1/1/23
ET1

SECTION XIII. Prescription Drug Coverage

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Covered Prescription Drugs.

Covered Prescription Drugs include, but are not limited to:

- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include, but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.

- Modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.

HC-PHR577 1/1/23
ET1

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

CERTIFICATE RIDER – North Carolina Residents

Rider Eligibility: Each Employee who is located in North Carolina

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of North Carolina group insurance plans covering insureds located in North Carolina. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNCRDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

HC-ELG243 01-19
ET

Covered Expenses

- charges made by a Hospital or ambulatory surgical facility for anesthesia and facility charges for services performed in the facility in connection with dental procedures for: Dependent children below age 9; covered persons with serious mental or physical conditions; or covered persons with significant behavioral problems. The treating provider must certify that hospitalization or general anesthesia is required in order to safely and effectively perform the procedure because of the person's age, condition or problem.
- charges made for or in connection with: the treatment of congenital defects and abnormalities, including those charges for your newborn child from the moment of birth; and with the treatment of cleft lip or cleft palate.
- charges for a qualified person for the diagnosis and evaluation of osteoporosis or low bone mass if at least 23 months have elapsed since the last Bone Mass Measurement was performed. More frequent follow up measurements will be covered when deemed Medically Necessary. Conditions that would be considered Medically Necessary include, but are not limited to monitoring insureds on long-term glucocorticoid therapy of more than 3 months; or a central Bone Mass Measurement to determine the effectiveness of adding an additional treatment program for a qualified person with low bone mass as long as the Bone Mass Measurement is performed 12 to 18 months from the start date of the additional program.
- charges made for surgical or non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) excluding appliances and orthodontic treatment.

HC-COV1284 01-22
ET1

Prescription Drug Benefits

Exclusions

More than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies. We will authorize payment for any prescription dispensed under a declared state of emergency or disaster issued by the North Carolina Governor or General Assembly, or by the President of the United States. If the covered person requesting coverage of the refill or replacement of the prescription resides in a county that is covered under a state of emergency or disaster regardless of the date upon which the prescription had most recently been filled by a pharmacist, if all of the following conditions apply:

- The North Carolina Commissioner of Insurance issues a Bulletin Advisory notifying insurance carriers of a declared disaster or state of emergency in North Carolina;
- The covered person requesting coverage of the refill or replacement prescription resides in a county that is covered under the declared disaster or state of emergency; and
- The prescription medication is requested within 29 days after the effective date of the declared disaster or state of emergency as stated in the Bulletin Advisory.

The time period for the waiver of prescription medication refills may be extended in 30-day increments by an order issued by the North Carolina Commissioner of Insurance. Cigna will cover the requested medication, in accordance with the terms of the plan, provided that additional refills still remain on the prescription and are consistent with the orders of the prescriber or the authority of the dispensing Pharmacy.

- quantity limitations shall be consistent with the original prescription and the extra or replacement fill may recognize proportionate dosage use prior to the declared disaster or state of emergency.

HC-PHR591 01-22
ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance. However, benefits for congenital defects or anomalies shall specifically include, but not be limited to, all necessary treatment and care needed by individuals born with cleft lip or cleft palate.

HC-EXC510 01-22
ET

Definitions

Dependent

The term child means a child born to you, a foster child, a foster child placed in the foster home, a child placed for adoption. A child includes an adopted child or foster child including that child from the first day of placement in your home regardless of whether the adoption has become final.

HC-DFS1723 01-22
ET

Dependent – Applies to Vision Only

The term child means a child born to you or a child legally adopted by you, or a foster child including that child from the first day of placement in your home regardless of whether the adoption has become final.

HC-DFS256 04-10
V1-ET

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

CERTIFICATE RIDER – Ohio Residents

Rider Eligibility: Each Employee who is located in Ohio

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Ohio group insurance plans covering insureds located in Ohio. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETOHRDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

Newborns are automatically covered for the first 31 days after birth. In order to continue the child's coverage after the end of that 31-day period, you must elect to insure your newborn child within 31 days after the date of birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

HC-ELG256 03-19
ET

Covered Expenses Under the Medical Plan

- charges made for or in connection with: (a) an annual cytologic screening (Pap smear) for detection of cervical cancer; (b) a single baseline mammogram for women ages 35 through 39. The total amount payable (including Deductibles and Copayments) for the mammogram cannot exceed 130% of the Medicare reimbursement amount. The provider may only bill for Deductibles and Copayments up to that amount and they may not Balance Bill for any charges over that. Screening mammography's must be performed in a health care facility or mobile mammography screening unit that is accredited under the American College of Radiology Accreditation Program or in a hospital; (c) a mammogram every two years for women ages 40 through 49, or an annual mammogram if a licensed Physician has determined the woman to be at risk; and (d) an annual mammogram for women ages 50 through 64. Your provider will indicate whether your mammogram is for preventive or diagnostic purposes.
- charges for any medical services necessary to administer prescribed off-label drugs.Coverage includes Medically Necessary services associated with the administration of the drug.

  Such coverage shall not be construed to do any of the following:

  - Require coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
  - Require coverage for experimental drugs not approved for any indication by the FDA;
  - Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the FDA;
  - Require reimbursement or coverage for any drug not included in the drug formulary or list of covered drugs specified in the policy;
  - Prohibit Cigna from limiting or excluding coverage of a drug, provided that the decision to limit or exclude coverage of the drug is not based primarily on the coverage of drugs described in this provision.
- charges for diagnostic and exploratory procedures to determine infertility, including surgical procedures to correct the medically diagnosed disease or condition of reproductive organs, including but not limited to endometriosis, collapsed/clogged fallopian tubes or testicular failure; in vitro fertilization, gamete intrafallopian transfer and zygote intrafallopian transfer are not covered.

Maternity

- charges for coverage for 48 hours of inpatient care following a vaginal delivery and 96 hours of inpatient care following a cesarean section for a mother and her newborn.
- any decision for early discharge (i.e. prior to the 48 or 96 hours) is to be made by the attending Physician or nurse mid-wife after conferring with the mother or person responsible for the mother or newborn.
- any length of stay beyond the 48 or 96 hours will be covered if determined Medically Necessary.

  Inpatient care will include:

  - medical services;
  - educational services; and
  - any other services that are consistent with protocols and guidelines developed by national pediatric, obstetric, and nursing professional organizations for these services (e.g. AAP/ACOG Guidelines).

Post-discharge Follow-up

- If a mother and newborn are discharged prior to the 48 or 96 hours, policies and contracts will also provide coverage for all Physician/advanced practice registered nurse-directed follow-up care provided during the first 72 hours after discharge. Coverage for follow-up care after that 72 hour period will be provided if the services are Medically Necessary.
- If a mother and newborn receive at least 48 or 96 hours of inpatient stay following a vaginal or cesarean section, respectively, then policies and contracts will provide coverage for follow-up care if it is determined Medically Necessary by the attending health care professionals.
- Coverage for follow-up care will apply to services provided in a medical setting (e.g. doctor's office or facility) or through home health care visits. Home health care visits must be conducted by a health care professional with knowledge and training in maternity and newborn care.

  Follow-up services will include:
  - physical assessment of the mother and newborn;
  - parent education;
  - assistance and training in breast and bottle feeding;
  - assessment of the home support system;
  - the performance of any Medically Necessary and appropriate clinical tests; and
  - any other services that are consistent with protocols and guidelines developed by national pediatric, obstetric, and nursing professional organizations for these services (e.g. AAP/ACOG Guidelines).

Virtual Care – Medical

Dedicated Virtual Providers/Telemedicine

Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through synchronous or asynchronous information and communication technology.

Virtual Physician Services/Telemedicine

Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through synchronous or asynchronous information and communication technology that are similar to office visit services provided in a face-to-face setting.

- charges made for Medically Necessary Synchronous Teledentistry.
- charges for screening, diagnosis and treatment of autism spectrum disorder. Treatment for autism spectrum disorder include evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed Physician who is a developmental pediatrician or a licensed Psychologist trained in autism who determines the care to be Medically Necessary, including any of the following: (a) Clinical therapeutic intervention; (b) Pharmacy care; (c) Psychiatric care; (d) Psychological care; (e) Therapeutic care.

Clinical Trials

- charges made for Routine Patient Care administered to an insured person participating in any stage of an Eligible Cancer Clinical Trial if that care would be covered under the plan if the insured was not participating in the trial.
- Routine Patient Costs are generally defined as items and services that typically would be covered under the plan for an individual not enrolled in a clinical trial.
- "Approved Clinical Trial" is defined as a Phase I, Phase II, Phase III, or Phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. The clinical trial must be federally approved or funded by one of the designated entities in the statute (outlined below). Routine costs for Approved Clinical Trials are covered.

The clinical trial must meet the following requirements; the study or investigation must meet 1, 2 or 3 below:

1. Be approved or funded by:
   A. the National Institutes of Health (NIH);
   B. the Centers for Disease Control and Prevention (CDC);
   C. the Agency for Health Care Research on Quality;
   D. the Centers for Medicare & Medicaid Services;
   E. cooperative group or center of any of the entities named in (A) through (D); or the Department of Defense or the Department of Veterans Affairs;
   F. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   G. Any of the following if the "Conditions For Departments" are met:
      - (i) The Department of Veterans Affairs.
      - (ii) The Department of Defense.
      - (iii) The Department of Energy.
2. Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

3. Involve a drug trial that is exempt from having such an investigational new drug application.

An "Eligible cancer clinical trial" means a cancer clinical trial that meets all of the following criteria:

- (a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
- (b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
- (c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
- (d) The trial does one of the following:
  - (i) Tests how to administer a health care service, item, or drug for the treatment of cancer;
  - (ii) Tests responses to a health care service, item, or drug for the treatment of cancer;
  - (iii) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
  - (iv) Studies new uses of a health care service, item, or drug for the treatment of cancer.
- (e) The trial is approved by one of the following entities:
  - (i) The National Institutes of Health or one of its cooperative groups or centers under the United States department of health and human services;
  - (ii) The United States Food and Drug Administration;
  - (iii) The United States Department of Defense;
  - (iv) The United States Department of Veterans' Affairs.
- (2) "Subject of a cancer clinical trial" means the health care service, item, or drug that is being evaluated in the clinical trial and that is not routine patient care.
- (3) "Health benefit plan" has the same meaning as in section 3924.01 of the Revised Code.
- (4) "Routine patient care" means all health care services consistent with the coverage provided in the health benefit plan or public employee benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial.
- (5) For purposes of this section, a health benefit plan or public employee benefit plan may exclude coverage for any of the following:
  - (a) A health care service, item, or drug that is the subject of the cancer clinical trial;
  - (b) A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
  - (c) An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration;
  - (d) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
  - (e) An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;
  - (f) A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.
- Coverage for cancer clinical trials is subject to all terms, conditions, exclusions and limitations that apply to any other coverage under the plan for services performed by Participating and non-Participating providers.
- Routine Patient Care means all health care services consistent with the coverage provided in the health benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial and that was not necessitated solely because of the trial.

Routine Patient Care does not include, and reimbursement will not be provided for:

- A health care service, item or drug that is the subject of the cancer clinical trial (i.e. the service, item or drug that is being evaluated in the clinical trial and that is not Routine Patient Care);
- A health care service, item or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- An investigational or experimental drug or device that has not been approved for market by the U.S. Food and Drug Administration;
- Transportation, lodging, food or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; or
- A service, item or drug that is eligible for reimbursement by a person other than the carrier, including the sponsor of the cancer clinical trial.

***For Ohio residents**: Routine patient care for Eligible Cancer Clinical Trials are covered. The insured does not need a medical referral from a participating health care professional nor do they need to provide medical and scientific information establishing the appropriateness of participation.*

HC-COV963 ET

The Schedule

The pharmacy Schedule is amended to indicate the following:

Oral Chemotherapy Medication

Prescription oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered at Network Pharmacies at 100% after deductible, if applicable and if applicable at non-Network Pharmacies, the same as the out of network medical cost share for injectable/IV chemotherapy.

SCHEDPHARM90-ohet

Prescription Drug Benefits

Limitations

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card. Your Provider may request a Step Therapy exemption. An exemption request will be granted or denied within 48 hours for a request related to urgent care services and 10 calendar days for all other requests. See your Appeals section of this certificate for your Appeal rights.

These requirements do not apply to prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions.

Supply Limits

Prescription drug coverage shall provide for medication synchronization for an insured if all of the following conditions are met: (1) the insured elects to participate in medication synchronization; (2) The insured, prescriber, and Pharmacist at a Network Pharmacy agree that medication synchronization is in the best interest of the insured; (3) The prescription drug meets the requirements to be eligible for inclusion in medication synchronization.

To be eligible a drug must: (1) Be covered under the plan; (2) Be prescribed for the treatment and management of a chronic disease or condition and be subject to refills; (3) Satisfy all relevant prior authorization criteria; (4) Not have any quantity limits, dose optimization criteria, or other requirements that would be violated if synchronized; (5) Not have any special handling or sourcing needs, as determined by the plan that require a single Designated Pharmacy to fill or refill the prescription; (6) Be formulated so that the quantity or amount dispensed can be effectively divided in order to achieve synchronization; (7) Not be a schedule II controlled substance, opiate, or benzodiazepine. A policy or plan shall authorize coverage of a prescription drug subject to medication synchronization when the drug is dispensed in a quantity or amount that is less than a thirty one (31) day supply. Medication synchronization applies only once for each prescription drug subject to medication synchronization for the same insured unless; a) the prescriber changes the dosage or frequency of administration of a prescription drug subject to medication synchronization or; b) the prescriber prescribes a different drug. Shall permit and apply a prorated daily cost-sharing rate for a supply of a prescription drug subject to medication synchronization that is dispensed at a Network Pharmacy. Requirement does not waive any cost sharing in its entirety.

"Medication synchronization" means a pharmacy service that synchronizes the filling or refilling of prescriptions in a manner that allows the dispensed drugs to be obtained on the same date each month.

"Cost-sharing" means the cost to an insured according to any coverage limit, Copayment, Coinsurance, Deductible, or other Out-of-Pocket expense requirements imposed by the policy or plan.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you may not receive coverage for the Specialty Prescription Drug Product.

HC-PHR569 01-23
ET

Payment of Benefits

Recovery of Overpayment on a Provider Claim

A payment made by Cigna to a provider is considered final two years after payment is made. After that date, the amount of the payment is not subject to adjustment, except in the case of fraud by the provider.

Cigna may recover the amount of any part of a payment that we determine to be an overpayment to the provider if the recovery process is initiated not later than two years after the payment was made. Cigna must provide notice in writing and specify covered person's name, date of service, amount of overpayment, claim number, detailed explanation of basis for overpayment, method in which payment was made including the date of payment and check number.

Cigna must give the provider opportunity to appeal an overpayment determination. If the provider fails to respond within 30 days of receipt of notice, elects not to appeal, or appeals the determination but decision is upheld, Cigna may initiate overpayment recovery. Cigna can permit the provider to repay the overpaid amount or have the amount recouped.

This section does not apply in cases of fraud by the provider, the insured or member, or Cigna with respect to the claim on which the overpayment or underpayment was made.

HC-POB149 03-19
ET

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued on a direct-payment basis by Cigna only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled To Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for Medicare; would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.

- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

  Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of Cigna's current offerings at the time the first premium is received based on its rules for Converted Policies. The Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where you reside, if a Converted Policy is permitted by such jurisdiction, and there is no alternative state program available.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

HC-CNV26
HC-CNV27 04-10
V1-ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered Under the Medical Plan

The plan or policy shall not limit or exclude coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy (a) it is recognized as safe and effective for the specific treatment prescribed according to any of the following: The AMA Drug Evaluations; The American Hospital Formulary Service; The U.S Pharmacopoeia Dispensing Information; or two articles from major peer-reviewed professional medical journals which meet the journalistic standards of the International Committee of Medical Journal Editors or the U.S. Department of Health and Human Services, if those articles are not contradicted by evidence presented in another article from such a journal; (b) it has been otherwise approved by the FDA; and (c) it has not been contraindicated by the FDA for the use prescribed. The law does not prohibit health plans from using drug formularies. The law does require coverage for any medical services necessary to administer a drug.

HC-EXC492 01-23
ET

Termination of Insurance

Special Continuation of Medical and/or Dental Insurance For Military Reservists and Their Dependents

If you are a Reservist, and if your Medical Insurance would otherwise cease because you are called or ordered to active military duty, you may continue Medical Insurance for yourself and your Dependents, upon payment of the required premium to your Employer, until the earliest of the following dates:

- 18 months from the date your insurance would otherwise cease, except that coverage for a Dependent may be extended to 36 months as provided in the section below entitled "Extension of Continuation to 36 months";
- the last day for which the required premium has been paid;
- the date you or your Dependent becomes eligible for insurance under another group policy;
- the date the group policy is canceled.

The continuation of Medical Insurance will provide the same benefits as those provided to any similarly situated person insured under the policy who has not been called to active duty.

"Reservist" means a member of a reserve component of the armed forces of the United States. "Reservist" includes a member of the Ohio National Guard and the Ohio Air National Guard.

Special Continuation of Medical Insurance

If your Active Service ends because of involuntary termination of employment, and if:

- you have been insured under the policy (or under the policy and any similar group coverage replaced by the policy) during the entire 3 months prior to the date your Active Service ends; and
- you are eligible for unemployment compensation benefits; and
- you pay the Employer the required premium;

your Medical Insurance will be continued until:

- you become eligible for similar group medical benefits or for Medicare;
- the last day for which you have made the required payment;
- 12 months from the date your Active Service ends; or
- the date the policy cancels;

whichever occurs first.

At the time you are given notice of termination of employment, your Employer will give you written notice of your right to continue the insurance. To elect this option, you must apply in writing and make the required monthly payment to the Employer within 31 days after the date your Active Service ends.

If your insurance is being continued under this section, the Medical Insurance for Dependents insured on the date your insurance would otherwise cease may be continued, subject to the provisions of this section. The insurance for your Dependents will be continued until the earlier of:

- the date your insurance for yourself ceases; or
- with respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent.

This option will not reduce any continuation of insurance otherwise provided.

HC-TRM140 12-18
ET

Medical Benefits Extension

Coverage will continue to be provided while you are confined to a Hospital following termination of coverage. Coverage will be provided for the specific medical condition causing the confinement and any other Medically Necessary treatment during that period of confinement.

This extension of coverage will end on the earliest of the following:

- the date the insured is discharged from the Hospital;
- the date the insured's attending Physician determines that the Hospital Confinement is no longer Medically Necessary;
- the date the insured exhausts the coverage available for the confinement and/or medical condition; or
- the effective date of coverage for the insured under another policy, plan or contract.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when a person's benefits cease.

HC-BEX31 04-10
V1-ET

Definitions

Dependent

Dependents are:

- any child of yours who is:
  - less than 26 years old.
  - you natural child, stepchild, or adopted child;
  - after having reached the limiting age, has been continuously covered under any health plan, and not eligible for coverage under the Medicaid or Medicare program.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

    Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.

It also includes a stepchild, a grandchild who lives with you, or a child for whom you are the legal guardian.

HC-DFS1690 01-23
ET

Synchronous, Real Time Communication

A live, two-way interaction between a patient and a dentist conducted through audiovisual technology.

HC-DFS1335 03-19
ET

Teledentistry

The delivery of dental services through the use of synchronous, real-time communication and the delivery of services of a dental hygienist or expanded function dental auxiliary pursuant to a dentist's authorization.

HC-DFS1336 03-19
ET

Telemedicine/Virtual Care

Telemedicine services means a mode of providing health care services through synchronous or asynchronous information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where the recipient is located.

HC-DFS1526 ET

How To File A Claim

Time Of Payment

Claims, either paper or electronic, will be paid by Us within 30 calendar days of receipt. However, if more time is needed to make a determination due to matters beyond Our control, We will notify You or Your representative within 30 days after receiving your claim. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the claim. The determination period will be suspended on the date Cigna sends such a notice of missing information, and resume on the date You or Your representative responds to the notice.

HCDFB-CLM78 06-21
ET

Definitions

Dependent

The term Dependent means:

- any child of Yours who is:
  - less than 26 years old.
  - 26 or more years ,old, unmarried, and primarily supported by You and incapable of self-sustaining employment by reason of mental or physical impairment which arose while the child was covered as a Dependent under this Plan, or while covered as a Dependent under a prior plan with no break in coverage of more than 63 days. Proof of the child's condition and dependence may be required to be submitted to Us within 31 days after the date the child ceases to qualify above.

The term child means a child born to You or a child legally adopted by You. It also includes a stepchild, a grandchild who lives with You, or a child for whom You are the legal guardian, or a child supported pursuant to a court order imposed on You (including a Qualified Medical Child Support Order).

HCDFB-DFS335 06-21
V2-ET

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

CERTIFICATE RIDER – Rhode Island Residents

Rider Eligibility: Each Employee who is located in Rhode Island

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Rhode Island group insurance plans covering insureds located in Rhode Island. These provisions supersede any provisions

in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETRIRDR

Important Notices

Rhode Island Mandatory Civil Unions Endorsement For Health Insurance

Purpose:

Rhode Island law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons. This endorsement is part of and amends this policy, contract or certificate to comply with Rhode Island law.

Definitions, Terms, Conditions And Provisions

The definitions, terms, conditions and any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a civil union established according to Rhode Island law.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Rhode Island law.

Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a civil union established according to Rhode Island law.

"Dependent" means a spouse, party to a civil union established according to Rhode Island law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent upon the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Rhode Island law.

"Child" or "covered child" means a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent upon the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Rhode Island law.

Caution: Federal Rights May Or May Not Be Available

Rhode Island law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Retirement Income Security Act of 1974 known as "ERISA," controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or

may not have access to certain benefits under this policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

HC-IMP105 01-12
V1-ET

Home Health Care Services

Charges for skilled care provided by certain health care providers during a visit to the home, when the home is determined to be a medically appropriate setting for the services. A visit is defined as a period of 2 hours or less. Home Health Care Services are subject to a maximum of 16 hours in total per day. Home Health Care Services are subject to a maximum of six home or office visits per month, three nursing visits per week, home health aide visits up to 20 hours per week and the following services as needed: physical, occupational or speech therapy as a rehabilitative service; respiratory service; medical social work; nutritional counseling; prescription drugs and medications lawfully dispensed only on the written prescription of a Physician; medical and surgical supplies, such as dressings, bandages and casts; minor equipment such as commodes or walkers; laboratory testing; x-rays; and EEG and EKG evaluations.

Home Health Care Services are covered when skilled care is required under any of the following conditions:

- the required skilled care cannot be obtained in an outpatient facility.
- confinement in a Hospital or Other Health Care Facility is not required.
- the patient's home is determined by Cigna to be the most medically appropriate place to receive specific services.

Covered services include:

- skilled nursing services provided by a Registered Nurse (RN); Licensed Practical Nurse (LPN); Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse (APRN).
- services provided by health care providers such as physical therapist; occupational therapist and speech therapist.
- services of a home health aide when provided in direct support of those Nurses and health care providers.
- necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.

Note: Physical, occupational, and other Outpatient Therapy Services provided in the home are covered under the Outpatient Therapy Services benefit shown in The Schedule.

The following are excluded from coverage:

- services provided by a person who is a member of the patient's family, even when that person is a health care provider.
- services provided by a person who normally resides in the patient's house, even when that person is a health care provider.
- non-skilled care, Custodial Services, and assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other services; self-care activities; homemaker services; and services primarily for rest, domiciliary or convalescent care.

Home Health Care Services, for a patient who is dependent upon others for non-skilled care and/or Custodial Services, is provided only when there is a family member or caregiver present in the home at the time of the health care visit to provide the non-skilled care and/or Custodial Services.

HC-COV1136 04-21
ET

Prescription Drug Benefits

Exclusions

- charges which you are not obligated to pay and/or for which you are not billed or for which you are not billed. This exclusion includes, but is not limited to:
  - any instance where Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.
  - charges of a non-Participating provider who has agreed to charge you at an In-Network benefit level or some other benefit level not otherwise applicable to the services received.

  In the event that Cigna determines that this exclusion applies, then Cigna shall have the right to:
  - require you and/or any provider or Pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna;
  - deny the payment of benefits in connection with the Covered Expense regardless of whether the provider of the pharmacy represents that you remain responsible for any amounts that your plan does not cover; and
  - reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover.
- charges or payment for arising out of healthcare-related services that violate state or federal law.

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- charges which you are not obligated to pay and/or for which you are not billed. This exclusion includes, but is not limited to:
  - any instance where Cigna determines that a provider or Pharmacy did not bill for you, or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.
  - charges of a non-Participating Provider who has agreed to charge you at an In-Network benefit level or some other benefit level not otherwise applicable to the services received.

  In the event that Cigna determines that this exclusion applies, then Cigna shall have the right to:
  - require you and/or any provider or Pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna;
  - deny the payment of benefits in connection with the Covered Expense regardless of whether the provider or the Pharmacy represents that you remain responsible for any amounts that your plan does not cover; or
  - reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover.

  Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.

Coordination of Benefits

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

HC-COB310 04-21
ET

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

CERTIFICATE RIDER – South Carolina Residents

Rider Eligibility: Each Employee who is located in South Carolina

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of South Carolina group insurance plans covering insureds located in South Carolina. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETSCRDR

Eligibility - Effective Date

Employee Insurance

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 31 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 31 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

HC-ELG1 04-10
V8-ET

The Schedule

The Medical Schedule is amended to indicate that no separate maximum/deductible shall apply to **Diabetic Equipment**.

The **Nutritional Evaluation** annual maximum shown in the Medical Schedule is amended to indicate the following:

"3 visits per person however, the 3 visit limit will not apply to treatment of diabetes."

SCHEDDENE-ET1

Covered Expenses

- charges made for Medically Necessary care and treatment of cleft lip and palate and any condition or illness which is related to or developed as a result of cleft lip and palate. This includes, but is not limited to oral/facial surgery, teeth capping prosthodontics, orthodontics, otolaryngology, and audiological care. If the procedures are also covered by a dental policy, medical benefits can be excluded for prosthodontics, including teeth capping, and orthodontics.
- charges for inpatient care for up to 48 hours after a vaginal delivery and up to 96 hours after a caesarean section for a mother and her newborn, payable as any other inpatient stay. The day of delivery or surgery will not count toward the length of stay. Any length of stay beyond the 48 or 96 hours will be covered if determined Medically Necessary. This does not prevent a mother and her newborn from being discharged earlier than the 48 or 96 hours if the mother and doctor agree to the earlier discharge.
- charges for mastectomy surgery to also provide coverage for prosthetic devices and reconstruction of the breast on which surgery for breast cancer has been performed and surgery and reconstruction of the non-diseased breast, if determined Medically Necessary by the patient's attending Physician with the approval of the insurer.

- charges made for at least 48 hours of inpatient care following a mastectomy. A shorter stay is acceptable when ordered by the attending Physician. In the case of an early release, charges for at least one home care visit will be covered, if ordered by the Physician.
- charges for a mammogram: 1) once for women age 35 to 39; 2) once every two years for women age 40 to 49; and 3) once a year for women who are at least 50. Coverage must also be provided for an annual pap smear. Coverage must be provided for additional pap smears when recommended by a Physician.
- charges made for treatment of Autistic Disorder, Asperger's Syndrome, Pervasive Developmental Disorder - Not Otherwise Specified and ABA therapy. Coverage is limited to treatment that is prescribed by the insured's treating medical doctor in accordance with a treatment plan, to include a diagnosis, proposed treatment by type, frequency, and duration of treatment, the anticipated outcomes stated as goals, the frequency by which the treatment plan will be updated, and the treating medical doctor's signature.

HC-COV1240 01-22
ET

Medical Pharmaceuticals

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician or Other Health Professional. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product’s FDA labeling.

HC-COV1241 01-22
ET

Prescription Drug Benefits

Exclusions

- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” sections of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

  The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug of Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of the prescribed indication in one of the following: United States Pharmacopoeia Drug Information; American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; or two articles from major peer-reviewed medical literature.

HC-PHR566 01-22
ET

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by Cigna only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to Cigna within 60 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled To Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

If you retire you may apply for a Converted Policy within 60 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death; (In the case of divorce, the former spouse must make written application and pay the required premium within 60 days after the entry of final decree.)
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for Medicare; would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

  Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of Cigna's current offerings at the time the first premium is received based on its rules for Converted Policies. The Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where you reside, if a Converted Policy is permitted by such jurisdiction, and there is no alternative state program available.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the

Policyholder will give you, on request, further details of the Converted Policy.

HC-CNV1 04-10
V3-ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

  The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of the prescribed indication in one of the following: United States Pharmacopoeia Drug Information; American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; or two articles from major peer-reviewed medical literature.

HC-EXC491 01-22
ET

Medical Benefits Extension

If the Medical Benefits under this plan cease for you or your Dependent and you or your Dependent is Totally Disabled on that date due to an Injury or Sickness, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group policy;
- the date you are no longer Totally Disabled;
- 12 months from the date your Medical Benefits cease; or
- 12 months from the date of termination.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when you or your Dependent's Medical Benefits cease.

HC-BEX32 04-10
V1-ET

Definitions

Dependent

The term child means a child born to you or a child legally adopted by you, including that child from the first day of

placement in your home regardless of whether the adoption has become final, or an adopted child of whom you have custody according to the decree of the court provided you have paid premiums. Adoption proceedings must be instituted by you, and completed within 31 days after the child's birth date, and a decree of adoption must be entered within one year from the start of proceedings, unless extended by court order due to the child's special needs.

HC-DFS981 10-16
ET

Emergency Service/Emergency Medical Condition

Emergency Services are covered inpatient and outpatient services that are furnished by a qualified provider and are needed to evaluate or stabilize an Emergency Medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would result in one of the following:

- Placing the health of the individual, or with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

HC-DFS263 04-10
V1-ETC

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

CERTIFICATE RIDER – Virginia Residents

Rider Eligibility: Each Employee who is located in Virginia

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legislative requirements of Virginia group insurance plans covering insureds located in Virginia. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETVARDR

How To File Your Claim

Payment of Claim

All benefits payable under the Policy are payable within 40 days of receipt of proof of loss. All or any portion of any benefits may be paid to the health care services provider.

HC-CLM8 01-11
V2-ET

Eligibility - Effective Date

Exception to Late Entrant Definition

A person will not be considered a Late Entrant when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to other available coverage; Employer contributions toward the other coverage have been terminated; he no longer qualifies in an eligible class for prior coverage; or if such prior coverage was continuation coverage and the continuation period has been exhausted; and he enrolls for this coverage within 30 days after losing or exhausting prior coverage; or if he is a Dependent spouse or minor child enrolled due to a court order within 31 days after the order is issued.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption or foster care, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective, on the date of marriage, birth, adoption, or placement for adoption or foster care.

HC-ELG261 01-19
ET

Prescription Drug Benefits

Limitations

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive benefits for such Prescription Drug Products you are required to try a

different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.

If your treating health care provider submits a request for a step therapy exception determination, the request must state the circumstance that qualifies for a step therapy exception.

We will respond to the exception request with our decision within three (3) business days of receipt of the exception request.

In cases where emergency circumstances exist, we will respond with our decision within 24 hours of receipt of an exception request.

If we grant an exception request, we will authorize coverage for the Prescription Drug Product.

You may request an appeal of any step therapy exception denial by following the appeals process.

HC-PHR527 01-21
ET

Termination of Insurance

Reinstatement of Medical Insurance

If your Medical Insurance ceases because of active duty in: the United States Armed Forces; the Reserves of the United States Armed Forces; or the National Guard, the insurance for you and your Dependents will be reinstated after your deactivation provided you apply for reinstatement and you are otherwise eligible.

Such reinstatement will be without the application of: a new waiting period. The remainder of any waiting period which existed prior to interruption of coverage may still be applied.

HC-TRM127 11-17
ET

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

CERTIFICATE RIDER – Washington Residents

Rider Eligibility: Each Employee who is located in Washington

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Washington group insurance plans covering insureds located in Washington. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETWARDR

Notice

Coordination of Benefits Included – See Table of Contents for Location of Coordination of Benefits Section. Your Benefits may be affected by other Insurance.

HC-CER1 02-16
V11-ET

Customer Service

HIPAA Privacy Statement

Your privacy is important to us. The following website explains how we collect and protect information about you:

www.cigna.com/privacyinformation

You may also request copies of this information by contacting customer service at the number shown on your ID card

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract or your rights under the law, you may contact the Office of Insurance Commissioner at 800-562-6900. If you have a concern about the qualifications or professional conduct of your mental

health service provider, please call the State Health Department at 800-525-0127.

Notice Regarding Coordination of Benefits

If you are covered by more than one health benefit plan and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.

CAUTION: All health plans have timely claims filing requirements. If you or your provider fails to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delay in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

American Indian Health Services

American Indians, who are covered by this plan, may use the services of the Indian Health System under the same terms and conditions as an insured who uses in-network benefits and services.

Pharmacy Disclosures

Your Prescription Drugs Rights

You have the right to safe and effective pharmacy services. You also have the right to know what drugs are covered by your plan and the limits that apply. If you have a question or concern about your prescription drug benefits, please contact Cigna at the phone number on the back of your ID card or visit www.cigna.com/product-disclosures, under Washington or visit www.mycigna.com. If you would like to know more about your rights or if you have concerns about your plan, you may contact the Washington state office of insurance commissioner at 1-800-562-6900 or www.insurance.wa.gov. If you have a concern about the pharmacists or pharmacies serving you, please contact the Washington state department of health at 360-236-4700, www.doh.wa.gov, or HSQACSC@doh.wa.gov.

1. The Prescription Drug coverage provided by this plan uses the following provisions in the administration of coverage:
   - Exclusion of certain Prescription Drug Products from the Prescription Drug List;
   - Therapeutic drug substitution;
   - Incentives for use of generic drugs; such as step-therapy requirements and cost share incentives;
   - Prior authorization requirements;
   - Prescription Drug List changes;
   - Supply limit requirements; and
   - Specialty Prescription Drug Product requirements.

   These provisions are explained in the **Prescription Drug Benefit** section of this certificate.
2. The **Prior Authorization Requirements** section of this certificate explains the process that you and your Physician must use to seek coverage of a Prescription Drug Product that is not on the Prescription Drug List or is not the preferred Prescription Drug Product for a covered medical condition.
3. You may be eligible to receive an emergency fill for a Prescription Drug Product at a non-Network Pharmacy if Cigna determines that the Prescription Order could not reasonably be filled at a Network Pharmacy. Your payment will be based on the Usual and Customary Charge submitted by the non-Network Pharmacy. You also may be eligible to receive an emergency fill for a Prescription Drug Product while a prior authorization request is being processed. The process for requesting this emergency fill and the cost share requirements for this emergency fill are described in the **Prescription Drug Benefit, Medication Synchronization and Emergency Fills Medication** section of this certificate.
4. The **Prescription Drug List Management and New Prescription Drug Products** sections in the **Prescription Drug Benefits** section of this certificate explain the process for developing coverage standards and the Prescription Drug Lists.
5. The **Prescription Drug List Management and New Prescription Drug Products** sections in **the Prescription Drug Benefits** section of this certificate explain the process for changing coverage standards and the Prescription Drug Lists. Additionally, the **Prior Authorization Requirements** section of this certificate explains the process that you and your Physician must use to seek coverage of a Prescription Drug Product that is not on the Prescription Drug List or is not the preferred Prescription Drug Product for a covered medical condition. The length of the authorization will depend on the diagnosis and Prescription Drug Product. There are instances when an approved Prescription Drug Product coverage exception may be grandfathered to allow ongoing coverage.
6. Coverage status of a Prescription Drug Product may change periodically. As a result of coverage changes the plan may require you to pay more or less for that Prescription Drug Product or try another covered Prescription Drug Product(s).

7. The Prescription Drug Product dispensing fee is considered to be a pharmacy-related service which is reimbursed by the plan.
8. The **Exclusion** section in the **Prescription Drug Benefits section of this certificate** lists the categories of excluded Prescription Drugs.

Items to be Available on Request

You may obtain copies of the following documents at www.cigna.com/product-disclosures, under Washington.

You may also request copies of the following documents by contacting customer service at the phone number listed on the back of your ID card, or by logging on to www.mycigna.com. Cigna will provide written information about this plan that includes the following information:

- any documents, instruments, or other information referred to in the Policy or certificate;
- Pharmacy question and answer document;
- a full description of the procedures to be followed by an insured for consulting a provider other than the primary care provider and whether the insured's primary care provider, or Cigna's medical director, or another entity must authorize the referral;
- procedures, if any, that an insured must first follow for obtaining prior authorization for health care services;
- a written description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between Cigna and a provider or network;
- descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to Specialists;
- an annual accounting of all payments made by Cigna which have been counted against any payment limitations, visit limitations, or other overall limitations on a insureds coverage under the plan; however, the individual requesting an annual accounting may only receive information about that individual's own care, and may not receive information pertaining to protected individuals who have requested confidential communications based on WA law;
- a copy of Cigna's grievance process for claim or service denial and for dissatisfaction with care; and
- accreditation status with one or more national managed care accreditation organizations, and whether Cigna tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data.
- access to and copies of all information relevant to a claim.
- the criteria, processes, strategies, evidentiary standards and other factors used to make medical necessity determinations of MH/SUD benefits and apply an NQTL to medical/surgical and MH/SUD benefits under the plan.
- a copy of the current Prescription Drug List.
- a list of participating primary care and specialty care providers.

Protected individual means: An adult covered as a dependent on the enrollee's health benefit plan, including an individual enrolled on the health benefit plan of the individual's registered domestic partner; or a minor who may obtain health care without the consent of a parent or legal guardian, based on state or federal law. It does not include an individual deemed not competent to provide informed consent for care.

HC-NOT116 01-20
ET

Your Rights and Protections Against Surprise Medical Bills and Balance Billing

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

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

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. "Out-of-network" providers may be permitted to bill you the difference between what your plan agreed to pay 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 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.

Insurers are required to tell you, via their websites or on request, which providers, hospitals, and facilities are in their networks. Hospitals, surgical facilities, and providers must tell

you which provider networks they participate in on their website or on request.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition, mental health or substance use disorder condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes care you receive in a hospital and in facilities that provide crisis services to people experiencing a mental health or substance use disorder emergency. You can't be balance billed for these emergency services, including services you may get after you're in stable condition.

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 these providers may bill you is your plan's in-network cost-sharing amount.

You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When can you be asked to waive your protections from balance billing:

Health care providers, including hospitals and air ambulance providers, can never require you to give up your protections from balance billing.

If you have coverage through a self-funded group health plan, in some limited situations, a provider can ask you to consent to waive your balance billing protections, but you are never required to give your consent. Please contact your employer or health plan for more information.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may file a complaint with the federal government at https://www.cms.gov/nosurprises/consumers or by calling 1-800-985-3059; and/or file a complaint with the Washington State Office of the Insurance Commissioner at their website www.insurance.wa.gov or by calling 1-800-562-6900.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

Visit the Office of the Insurance Commissioner Balance Billing Protection Act website for more information about your rights under Washington state law.

HC-NOT132 01-22
ET

Discrimination is Against the Law

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

Cigna:

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

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

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

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at:

https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status

or by phone at 1.800.562.6900, 1.360.586.0241 (TDD).

Complaint forms are available at:

https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx

HC-NOT127 01-21
ET

Health Care Benefit Manager

A health care benefit manager ("HCBM") is any person or entity that provides services to or acts on behalf of a health carrier or employee benefits program. HCBMs directly or indirectly impact the determination or use of benefits for or patient access to health care services, drugs and supplies.

HCBMs include, but are not limited to, specialized benefit types such as pharmacy, radiology, laboratory and mental health. The services of an HCBM also include: Prior authorization or preauthorization of benefits or care, certification of benefits or care, medical necessity determinations, utilization review, benefit determinations, claims processing and repricing for services and procedures, outcome management, provider credentialing and re-credentialing, payment or authorization of payment to providers and facilities for services or procedures, dispute resolution, grievances or appeals relating to determinations or utilization of benefits, provider network management and disease management.

A current list of HCBMs for your plan is available at www.cigna.com/product-disclosures.

HC-NOT128 01-21
ET

Eligibility - Effective Date

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance will be automatically insured for Medical Insurance for the first 31 days of life. If payment of an additional premium is required to provide coverage for a child, to continue coverage beyond 31days, you must elect Dependent Medical Insurance for your newborn child within the 60 day enrollment period which begins on the first day of birth. If Dependent Medical Insurance is not elected within the 60 day enrollment period, you may be required to wait until the next plan enrollment period to enroll the child for coverage under the plan. Coverage shall include, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth.

HC-ELG305 01-20
ET

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

For children, you may designate a pediatrician as the Primary Care Physician.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which you requested the change.

HC-IMP1
V10-ET

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

If your request for Experimental and Investigational treatment is denied, Cigna will notify you in writing within 20 working days. This review period will be extended beyond 20 working days only if you provide your informed written consent to Cigna.

PAC will not be required for mental health treatment rendered by a state Hospital when you or your Dependent are involuntarily committed.

We will not retroactively deny coverage for:

- emergency and non-emergency care that had Prior Authorization under the plan's written policies at the time the care was rendered; or
- care based on standards and protocols not communicated within a sufficient time for your Physician, health care provider or facility to modify care.

Pre-Admission Certification is not required for withdrawal management services or inpatient or residential Substance Use Disorder treatment in a behavioral health agency specializing in addiction and withdrawal management, which is licensed or certified by the State of Washington. A review for Medical Necessity may later be required after two business days for inpatient or residential treatment at a behavioral health agency and after three days at a behavioral health agency for withdrawal management services.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Medical Benefits

Continuity of Care

- There may be instances in which your Participating Provider becomes unaffiliated with Cigna's network. In such cases you will be notified and provided assistance with selecting a new provider.
- However, under special medical circumstances, you may be able to continue seeing your provider, even though he or she is no longer affiliated with Cigna. This allows continued, uninterrupted care until safe transfer to a Participating Provider can be arranged. If you are undergoing an active course of treatment for an acute or chronic condition and continued treatment is Medically Necessary, you may be eligible to receive continuing care from the non-Participating Provider for at least 60 days or until the end of the next open enrollment period, subject to the treating provider's agreement. You may also be eligible to receive continuing care if you are in your second or third trimester of pregnancy. In this case, continued care may be extended through your delivery and include a period of postpartum care.
- You may request continuity of care from Cigna after your Participating Provider's termination. Continuity of care must be Medically Necessary and approved in advance by Cigna. Your provider must agree to accept our reimbursement rate and to abide by Cigna's policies and procedures and quality assurance requirements. Continuity of care will cease if your treatment is successfully transitioned to a Participating Provider.
- There may be circumstances when continued care by a provider no longer participating in Cigna's network will not be available, such as when the provider loses his or her license, is terminated for cause, or retires.

HC-PAC126 01-20
ET

Prior Authorization/Pre-Authorized

Prior Authorization is not required for withdrawal management services or inpatient or residential substance use disorder treatment in a behavioral health agency specializing in addiction and withdrawal management, which is licensed or certified by the State of Washington. A review for Medical Necessity may later be required after two business days for inpatient or residential treatment at a behavioral health agency and after three days at a behavioral health agency for withdrawal management services.

HC-PRA57 01-22
V1-ET

Covered Expenses

- charges made in connection with mammograms for breast cancer screening if prescribed by a Physician, an advanced registered nurse practitioner or a physician assistant.
- charges made for screening prostate-specific antigen (PSA) test.

- charges made for general anesthesia services and related facility charges in conjunction with any dental procedure performed in a Hospital or Free-Standing Surgical Facility if such anesthesia services and related facility charges are Medically Necessary because the covered person:
  - is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
  - has a medical condition that the person's Physician determines would place the person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the person's Physician.
- charges for Medically Necessary donor human milk in accordance with the Washington State requirements for inpatient use when ordered by a licensed health care provider with prescriptive authority or an international board certified lactation consultant certified by the international board of lactation consultant examiners for an infant who is medically or physically unable to receive maternal human milk or participate in chest feeding or whose parent is medically or physically unable to produce maternal human milk in sufficient quantities or caloric density or participate in chest feeding.
- charges made for orally administered anti-cancer medication prescribed to kill or slow cancer cell growth are paid at the same cost share as intravenous or injectable anti-cancer drugs.
- charges for the treatment for insulin using diabetes, non-insulin using diabetes, or elevated blood glucose levels induced by pregnancy, including:
  - diabetes equipment including blood glucose monitors, insulin pumps and accessories, insulin infusion devices, foot care appliances for prevention of complications associated with diabetes;
  - diabetes outpatient self-management training and education.
- charges made for ABA therapy.
- charges made for acupuncture.
- Gender Transition - Charges for services related to gender transition including gender reassignment surgery. Coverage when applicable includes behavioral counseling, hormone therapy, genital reconstructive surgical procedures, and initial mastectomy or breast reduction.
- Gender Transition – Additional services - charges for additional masculinization and feminization services when rendered in conjunction with treatment of gender dysphoria, including breast augmentation with or without prosthetic implant, facial feminization surgery, thyroid cartilage reduction, speech therapy, voice feminization surgery and electrolysis epilation for the face and genitalia, when Medically Necessary.

Virtual Physician Services

Includes charges for the delivery of real-time medical and health-related services, consultations and remote monitoring as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting. Coverage includes services provided through audio only.

Enteral Nutrition

Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism (e.g., disorders of amino acid or organic acid metabolism) including phenylketonuria (PKU) and Medically Necessary elemental formula, regardless of delivery method, when a licensed provider with prescriptive authority diagnoses a patient with an eosinophilic gastrointestinal associated disorder and orders and supervises the use of the elemental formula.

HC-COV1464 01-24

ET1

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) disorders.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for a continuous course of dental treatment for an Injury to teeth are covered.

HC-EXC577 01-24

ET1

The Schedule

The following supersedes any similar provisions shown in your pharmacy schedule:

For all insulin drugs covered by this plan your cost share amount will be capped so that the amount you are required to pay for all covered prescription insulin drugs for each 30-day

supply will not exceed $35 dollars, per prescription. Deductible will be waived.

If applicable, the following text that appears under **Patient Assurance Program** in your Pharmacy Schedule is amended as follows:

Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your Deductible and counts toward your Out-of-Pocket Maximum.

Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your Deductible and counts towards your Out-of-Pocket Maximum.

SCHEDPHARM90-waet2

Prescription Drug Benefits

Limitations

Prescription Topical Ophthalmic Products

A pharmacist may, without consulting a Physician or obtaining a new prescription or refill authorization from a Physician, provide for one early refill of a prescription for topical ophthalmic products if:

- the refill is requested by a patient at or after seventy percent of the predicted days of use of :
  - the date the original prescription was dispensed to the patient; or
  - the date that the last refill of the prescription was dispensed to the patient;
- the prescriber indicates on the original prescription that a specific number of refills will be needed; and
- the refill does not exceed the number of refills that the prescriber indicated.

Medication Synchronization and Emergency Fills Medication

Medication synchronization refers to the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period.

If you or your Dependent requests medication synchronization for a new prescription, your prescription may be filled as follows:

- for less than a one-month supply of the Prescription Drug or Related Supply if synchronization will require more than a fifteen-day supply of the Prescription Drug or Related Supply; or
- for more than a one-month supply of the Prescription Drug or Related Supply if synchronization will require a fifteen-day supply of the Prescription Drug or Related Supply or less.

Upon your request, the prescribing provider or pharmacist shall:

- Determine that filling or refilling the prescription is in your best interest, taking into account the appropriateness of synchronization for the drug being dispensed;
- Inform you that the prescription will be filled to less than the standard refill amount for the purpose of synchronizing your medications; and
- Deny synchronization on the grounds of threat to patient safety or suspected fraud or abuse.

Emergency fill refers to a limited dispensed amount of medication that allows time for the processing of a prior authorization request. If you or your Dependent request an emergency fill, the authorized amount of the emergency fill will be no more than the prescribed amount up to a seven day supply or the minimum packaging size available at the time the emergency fill is dispensed.

Emergency fill only applies to those circumstances where a patient presents at a Participating Pharmacy with an immediate therapeutic need for a prescribed medication that requires a prior authorization. An emergency fill does not necessarily constitute a covered health service under this plan. Determination as to whether the emergency fill is a covered health service under this plan will be made as part of the prior authorization process.

The cost sharing for a Prescription Drug or Related Supply subject to coinsurance that is dispensed for less than the standard refill amount for the purpose Medication Synchronization or emergency fills will be adjusted. The cost sharing for Prescription Drug or Related Supply with a copayment that is dispensed for less than the standard refill amount for the purpose of purpose Medication Synchronization or emergency fills will be adjusted by:

- Dividing the insured’s copayment for the drug by the normal day supply for the medication to find the Daily Member Cost.
- Multiply the Daily Insured Cost of the drug by the day supply being used. This is the amount Cigna will use to apply for the copayment.

Prior Authorization Requirements

If a prior authorization request is approved, your Physician will receive confirmation within forty-eight hours for an urgent care review, and within 5 calendar days for a non-urgent care review. The authorization will be processed in our

claim system to allow you to have coverage for those Prescription Drug Products. The length of the authorization will depend on the diagnosis and Prescription Drug Products. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Products has been approved, you can contact the Pharmacy to fill the covered Prescription Order or Refill.

If a prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Products is not authorized within forty-eight hours for an urgent care review and within 5 calendar days for a non-urgent care review.

If the information provided is not sufficient to approve or deny the claim, Cigna will, within twenty-four hours for an urgent care review request, and within 5 business days for a non-urgent care review request, request that the Physician submit additional information to make the prior authorization determination. Cigna will give the Physician forty-eight hours for an urgent care review request or 5 calendar days for a non-urgent care review request to submit the requested information. Cigna will then approve or deny the request within forty- eight hours for an urgent care review or 4 calendar days for a non-urgent care review of the receipt of the requested additional information.

Whenever there is an adverse determination resulting in a denial, Cigna will notify the requesting Physician by one or more of the following methods: phone, fax and/or secure electronic notification, and also notify you or your Dependent in writing or via secure electronic notification. The notification of the denial will include the specific reason for the denial as well as information on how to appeal the decision. Status information will be communicated to the billing Pharmacy, via electronic transaction, upon Cigna's receipt of a claim after the request has been denied. Cigna will transmit these notifications within the time frames specified above based on if the review was urgent or non-urgent and in compliance with United States Department of Labor standards. If the request was made by the Pharmacy, notification will also be made to the prescriber.

A non-urgent care review request refers to any request for approval of care or treatment where the request is made in advance of the patient obtaining medical care or services, or a renewal of a previously approved request, and is not an urgent care request.

An urgent care review request refers to any request for approval of care or treatment where the passage of time could seriously jeopardize the life or health of the patient, seriously jeopardize the patient's ability to regain maximum function or, in the opinion of a provider with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the Prescription Drug Products should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

When Cigna establishes new limitations on coverage of a Prescription Drug Product, Cigna will ensure that prior notice of the change will be provided as soon as is reasonably possible to insureds who filled a prescription for the drug within the prior three months.

If an insured agrees to receive electronic notice and such agreement has not been withdrawn, Cigna will provide either electronic mail notice or written notice by first class mail at the last known address of the insured.

If these notice methods are not available because Cigna does not have contact information for the insured, Cigna will post notice on its web site or at another location that may be appropriate.

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

Drug Substitution

FDA approved Prescribed Drug Products that are the sole prescription drug available for a covered medical condition will be covered. Coverage for a non-Prescription Drug List Prescription Drug Product will not be excluded if the only Prescription Drug List drug available for your covered condition is one that you cannot tolerate or that is not clinically efficacious for you.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

You may obtain a twelve-month refill of covered contraceptive drugs if prescribed by your provider or you may

request a smaller supply. If available, you may receive the contraceptives on site at the doctor's office. During the last quarter of the plan year the refill amount may be limited if a twelve-month supply of the contraceptive drug has already been dispensed during the plan year.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-PHR539 01-21
ET

Prescription Drug Benefits

Exclusions

- vitamins, except FDA approved prenatal vitamins unless coverage for such product(s) is required by federal or state law.

HC-PHR703 01-24
ET

Payment of Benefits

Medical

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person or facility to whom it was made; or offset the amount of that overpayment from a future claim payment.

Except in the case of fraud, when an overpayment has been made by Cigna to a healthcare provider, Cigna will not have the right to:

(a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless the request is made in writing to the provider within twenty-four months after the date that the payment was made; or

(b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why Cigna believes the provider owes the refund. If a provider fails to contest the request in writing to Cigna within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

Cigna will not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim:

(a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within thirty months after the date that the payment was made; or

(b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why Cigna believes the provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If a provider fails to contest the request in writing to Cigna within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

Cigna may at any time request a refund from a health care provider of a payment previously made to satisfy a claim if:

(a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and

(b) Cigna is unable to recover directly from the third party because the third party has either already paid or will pay the provider for the health services covered by the claim.

HC-POB158 01-19
ET

Termination of Insurance

Continuation of Insurance During Strike, Lockout or Other Labor Dispute

If your Medical Insurance will end due to a strike, lockout, or other labor dispute, under Washington law, you may elect to continue medical benefits for yourself and your insured Dependents. Your Employer will notify you of your right to continue your medical coverage. This notice will specify the amount of your premium payment, when your premium payments are due and the address to mail your payment. You must complete the application included with the notice and return it to your Employer with the required premium.

Medical benefits for your continued coverage will be those in effect on the day before the labor dispute began.

Your medical coverage will be continued until the earlier of:

- the last day for which you have made any required contribution for the insurance;

- the date the group policy terminates;
- the end of a period 6 months from the date your continued coverage began.

You must notify your Employer in writing if you become eligible for other group medical coverage prior to the end of the continuation period.

HC-TRM109 ET

Definitions

Concurrent Care Coverage Determination

Concurrent Care Coverage Determination means a medical necessity determination that is made during the period when the health care services or supplies are being provided to a customer including a) during on-going inpatient, intensive outpatient or residential behavioral healthcare treatment, b) during ongoing ambulatory care.

HC-DFS871 ET

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability.

    Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. The plan may require proof not more frequently than annually after the two year period following the child's attainment of the limiting age.

The term child means a child born to you or a child legally adopted by you including a child for whom you assume legal obligation for total or partial support, in anticipation of adoption, but with no requirement that the adoption be final. It also includes a stepchild. If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent or Dependent spouse unless the Dependent or Dependent spouse declines Employee coverage. A child under age 26 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee.

No one may be considered as a Dependent of more than one Employee.

HC-DFS1758 01-22
ET

Domestic Partner

A Domestic Partner is defined as a person who has a valid domestic partner registration in Washington.

HC-DFS1608 01-21
ET

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets, injection aids, test strips for glucose monitors, visual blood sugar reading and urine testing strips, prescriptive oral agents for controlling blood sugar levels, glucogen emergency kits), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

HC-DFS68 V7-ET

Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)

Although federal law does not extend FMLA rights to Domestic Partners, this plan will extend these same continuation benefits to Domestic Partners (and their children if not legal children of the Employee) to the same extent they are provided to spouses and legal children of the Employee.

HC-FED99 01-24
V3-ET

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual

coverage according to any “Conversion Privilege” shown in your certificate.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-Existing Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

If your coverage under this Plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

Although federal law does not extend USERRA rights to Domestic Partners, this Plan will extend these same continuation benefits to Domestic Partners (and their children if not legal children of the Employee) to the same extent they are provided to spouses and legal children of the Employee.