University of New England

ANNUAL COMPLIANCE RIDER

EFFECTIVE DATE: January 1, 2025

ACMEM25
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This document printed in December, 2024 takes the place of any documents previously issued to you which

Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

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

ANNUAL COMPLIANCE RIDER

No. ACMEM25

Policyholder: University of New England

charged for a service. This is called "**balance billing**". This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

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

You are protected from balance billing for:

- **Emergency services** – If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing 1 0 43. Q q]TJ94 93[“n2rom)1, tyoinsurotec,83499dyou hunt ards). Y34999Tm [are ncy or when you s]T

toll-free number on your ID card. Comparable Health Care Services are: (1) Physical and Occupational Therapy services; (2) Radiology and imaging services; (3) Laboratory services; and (4) Infusion therapy services.

Coverage for Certain Out-of-Network Non-Emergency Services

If you elect to have a Comparable Health Care Service from an Out-of-Network provider whose price for the service is the same or less than the Maine statewide average for the same service based on information in the Maine Health Data Organization's (MHDO) website www.comparemaine.org, the carrier Cigna will cover the service at the provider's charge. Upon request by you, the carrier must also apply the payments made by you for that service to your In-Network Deductible and/or Out-of-Pocket maximum as specified in your health plan, as if the services were rendered by an In-Network provider. The services eligible for reimbursement on this basis include: (1) Physical and Occupational Therapy services; (2) Radiology and imaging services; (3) Laboratory services; and (4) Infusion therapy services rendered in Massachusetts, New Hampshire, or Maine by a provider enrolled in the MaineCare program and participating in Medicare.

Eligibility - Effective Date

The following language regarding "Acquiring a new Dependent" under **Eligibility – Effective Date** section has been added to your medical certificate:

Acquiring a new Dependent

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, custody order or if your Dependent lost eligibility for other coverage, you may request special enrollment. The special enrollment request must be received within 30 days after the occurrence of the special enrollment event. Dependents enrolled due to a special enrollment event will not be considered Late Entrants. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. If the special enrollment event is due to a change in custody of a child coverage will be effective as of the date of the order and coverage as the result of marriage will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

The Schedule

Any existing paragraphs regarding "Maximum Reimbursable Charge" in **The Schedule** of your medical certificate are hereby replaced as follows as a result of the Consolidated Appropriations Act - No Surprise Bill:

Maximum Reimbursable Charge

The Maximum Reimbursable Charge for Out-of-Network services other than those described in The Schedule sections Out-of-Network Charges for Certain Services and Out-of-Network Emergency Services Charges and Out-of-Network Air Ambulance Services Charges is determined based on the lesser of the provider's normal charge for a similar service or supply;

or the amount agreed to by the Out-of-Network provider and Cigna, or a policyholder-selected percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable reimbursement for the same or similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.

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The Schedule

The following text is hereby added to any covered Out-of-Network benefit that includes a Coinsurance amount in **The Schedule**

The Schedule

section for information regarding coverage on oral contraceptives.

The following text regarding “Postpartum Care” is added to the **Covered Expenses** section of your medical certificate:

Postpartum Care

Charges for maternity benefits must provide coverage for 12 months following childbirth for postpartum care services. Postpartum care services and support must include coverage for development of a postpartum care plan including:

- contact with the patient within 3 weeks of the end of pregnancy;
- comprehensive postpartum visit, including full assessment of the patient’s physical, social and psychological well-being; and
- treatment of complications of pregnancy and childbirth, including pelvic floor disorders and postpartum depression; assessment of risk factors for cardiovascular disease; and care related to pregnancy loss.

Covered Expenses

The following language replaces the existing language under “Hospice Care Services” in the **Covered Expenses** section of your medical certificate:

Hospice Care Services

Charges for services for a person diagnosed with advanced Illness (having a life expectancy of twelve or fewer months). Services provided by a Hospice Care Program are available to those who have ceased treatment and to those continuing to receive curative treatment and therapies.

A Hospice Care Program rendered by a Hospice Facility or Hospital includes services:

- by a Hospice Facility for Room and Board and Services and Supplies;
- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies.

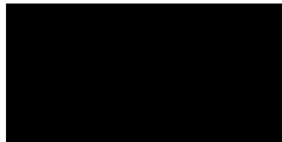
A Hospice Care Program rendered by an Other Health Care Facility or in the Home includes services:

- part-time or intermittent nursing care by or under the supervision of a Nurse;
- part-time or intermittent services of an Other Health Professional;
- physical, occupational and speech therapy;
- respite care;
- medical supplies;
- drugs and medicines lawfully dispensed only on the written prescription of a Physician;
- laboratory services;
- but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- services for any period when you or your Dependent is not under the care of a Physician;
- services or supplies not listed in the Hospice Care Program;
- to the extent that any other benefits are payable for those expenses under the policy;
- services or supplies that are primarily to aid you or your Dependent in daily living.

Covered Expenses



Covered Expenses

External Prosthetic Appliances and Devices

The bullet below has been added under “Prostheses/Prosthetic Appliances and Devices” in the **Covered Expenses - External Prosthetic Appliances and Devices** section of your medical certificate:

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- prosthetic devices for persons age 18 and under that are determined by the person’s provider to be the most appropriate model that meets the medical needs of the person for recreational purposes, as applicable, to maximize the ability to ambulate, run, bike and swim and to maximize upper limb function.

The Schedule

The pharmacy schedule is amended to add the following:

Insulin Drugs

For all insulin drugs covered by this plan your total out-of-pocket responsibility will not exceed $35 per 30 day supply, regardless of the amount of insulin needed to fill your insulin prescriptions.

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Prescription Drug Benefits

The following replaces the corresponding text found in the **Prescription Drug Benefits Covered Expenses** section of your medical certificate.

Covered Expenses

Coverage under your plan’s Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure. This includes:

- charges for abuse-deterrent opioid analgesic drug products.
- charges for one type of covered HIV infection prevention drugs (pre-exposure prophylaxis, post-exposure prophylaxis, or other drugs approved by the FDA for the prevention of HIV infection) at no cost share.

Prescription Drug Benefits

Prior Authorization Requirements

The following text is added to the **Prescription Drug Benefits Limitations** section of your medical certificate:

We will approve prior authorization requests for Prescription Drug Products on the Prescription Drug List prescribed to assess or treat a serious mental illness.

Exclusions, Expenses Not Covered and General Limitations

The following exclusion regarding “Hearing Aids” found in the **Exclusions, Expenses Not Covered and General Limitations** section of your medical certificate is hereby NULL and VOID:

- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as provided for in Covered Expenses. A hearing aid is any device that amplifies sound.

Medical Benefits Extension Upon Policy Cancellation

The following bullets regarding “Totally Disabled” found in the **Medical Benefits Extension Upon Policy Cancellation** section of your medical certificate have been revised to read as follows:

Totally Disabled

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

- if you were gainfully employed prior to disability, you are unable to engage in any gainful occupation for which you are reasonably suited by training, education, and experience; and
- if you were not gainfully employed prior to disability, you are unable to engage in most normal activities of a person of lik nr in0 1 0 164.18800354 cm Q q 1 (ampli)0 0 1 0 264.68099dcAA

Definitions

The following **Disability** definition is being added to the **Definitions** section of your medical certificate:

Disability

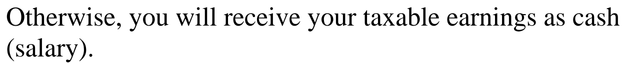
A physical, mental, intellectual or developmental Disability that renders a person incapable of self-sustaining employment.

Definitions

The following **Evidence-Based Practices** definition is being added to the **Definitions** section of your medical certificate:

Evidence-Based Practices

Evidence-Based Practices means clinically sound and scientifically based policies, practices and programs that reflect expert consensus on the prevention, treatment and recovery science, including, but not limited to, policies, practices and programs published and disseminated by the Substance Abuse and Mental Health Services Administration and the Title IV-E Prevention Services Clearinghouse within the United States Department of Health and Human Services, the What Works Clearinghouse within the United States



Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed:

- if you meet Special Enrollment criteria and enroll as described in the Special Enrollment section; or
- if your Employer agrees, and you meet the criteria shown in the following Sections B through H and enroll for or change coverage within the time period established by your Employer.

B. Change of status

A change in status is defined as:

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

C. Court order

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

D. Medicare or Medicaid eligibility/entitlement

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

E. Change in cost of coverage

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

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

F. Changes in coverage of spouse or Dependent under another employer's plan

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

G. Reduction in work hours

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

H. Enrollment in a Qualified Health Plan (QHP)

Employee: The Employee seeks to enroll in a QHP through an Exchange during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through an Exchange for new coverage effective beginning no later than the day immediately following the last day 0 43.s

Women’s Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

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