University of New England

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2025

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

[redacted]

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,

- 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.

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

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in The Schedule. Payment for the following is specifically excluded from this plan:

- 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 cancer in authoritative reference compendia as identified by the secretary of the U.S. Department of Health and Human Services.

HC-EXC562 01-24
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.

Employee

The term Employee means an Employee as determined by your Employer who is currently in Active Service. 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

[redacted]

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 18 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-COV1415 01-24
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.

- 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-EXC554 01-24
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

[redacted]

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

[redacted]

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. I(iss)-1(u1 0 89.gps contriLl1(nd has)] TJ 1 0 0 -1 0

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;
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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

tick-borne disease if the drug has been approved by the United States Food and Drug Administration.

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

Virtual Care

Virtual Physician Services

Includes charges for the delivery of real-time 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.

Includes charges for the delivery of real-time mental health and Substance Use Disorder consultations and services, via secure telecommunications technologies that shall include video capability, telephone and internet, when such consultations and services are delivered by a behavioral provider and are similar to office visit services provided in a face-to-face setting.

HC-COV1457 01-23
ET

Mental Health and Substance Use Disorder Services

Coverage includes evidence-based early treatment of a serious mental illness in an individual under age 26:

- coordinated specialty care for first episode psychosis treatment based on the Recovery After an Initial Schizophrenia Episode (RAISE) treatment model, excluding education and employment support elements of the model.
- assertive community treatment (ACT) and community support team (CST) treatment. ACT and CST both mean bundled services delivered through a multi-disciplinary team of Mental Health professionals.

HC-COV1459 01-23
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

- charges for Medically Necessary epinephrine injectors for persons age 18 and younger.

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

- 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.

HC-PHR700 01-23
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-PHR730 01-23
ET

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

CERTIFICATE RIDER – Kansas Residents

form, and a fully executed release form pertaining to medical records. Upon request from the Commissioner, the covered person or insurer/HMO must provide pertinent information within five business days. The Commissioner will negotiate contracts with external review organizations, allow the participants to provide additional written information, make a decision on the request within ten business days of receiving all necessary information, and notify the covered person, provider or designee in writing if the request for external review was granted. The external review organization chosen by the Commissioner will issue a binding written decision to the covered person, insurer and Commissioner within 30 business days, expedited resolution when an emergency condition exists within seven business days.

HC-IMP42 04-10
V1-ET

Eligibility - Effective Date

Late Entrant - Employee

You are a Late Entrant if:

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Association 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 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; 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 treatment that is 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.

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 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.

[redacted]

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 if applicable at non-participating pharmacies, the same as the out of network medical cost share for injectable/IV chemotherapy.

SCHEDPHARM90-kset

Prescription Drug Benefits

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule. Your benefits may vary depending on which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

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. Additionally, the plan shall provide coverage for psychotherapeutic Prescription Drug Products used for the treatment of mental illness on a basis no less favorable than coverage provided for other Prescription Drug Products.

HC-PHR511 01-24
ET

Termination of Insurance

Special Continuation of Medical Insurance

If your insurance would otherwise cease for any reason other than failure to make any required contribution, and if you have been insured for at least three consecutive months, and if you pay the required premium, your Medical Insurance will be continued until the earliest of:

- 18 months from the date the insurance would otherwise cease;
- the last day for which you have paid the required premium;

Within 31 days after the date the insurance would otherwise cease, you may elect such continuation by paying the required premium.

If your insurance is being continued as outlined above, the insurance for any of your Dependents insured on the date your insurance would otherwise cease may be continued, subject to the above provisions. The insurance will be continued until the date your insurance ceases.

Dependent Medical Insurance after Divorce

If insurance for any of your Dependents would otherwise cease because of divorce or annulment of marriage, Medical Insurance for that Dependent may be continued upon payment of the required premium. However, the insurance on any of your Dependents will cease on the earliest date below:

- 18 months from the date the insurance would otherwise cease;
- the last day for which the required premium has been paid.

In any case, Dependent Insurance on any of your children will cease when that child no longer qualifies as your Dependent for a reason other than one due to dissolution of marriage.

If you die, any other terms which continue Dependent Insurance after your death will apply.

Conversion Available Following Continuation

The provisions of the "Medical Conversion Privilege" section

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-BEX68 01-24
ET

The Schedule

The Medical Schedule in your certificate is amended to include the following provision (subject to the same terms and conditions as any other illness):

Elective Abortion
Abortion means the use or prescription of any instrume medicine, drug or any other substance or device to terminate the pregnancy of a woman known to be pregr with an intention other than to increase the probability o live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma criminal assault on the pregnant woman or her unborn child and which causes the premature termination of the pregnancy. Elective means an abortion for any reason other than to prevent the death of the mother upon whom the abortio performed; provided, that an abortion may not be deem one to prevent the death of the mother based on a clair diagnosis that she will engage in conduct which will res in her death.

HC-RDR37 04-10
V1-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. A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the plan, this definition also includes:

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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 another group plan (insured or uninsured) and is not covered under substantially similar benefits by an individual insurance policy 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.

The Converted Policy may 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.

The Schedule

Oral Chemotherapy Medication

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

Note: A health plan cannot impose a cost share of more than $100 per 30 day prescription.

A customer may not pay a cost share for a covered prescription insulin drug in excess of $30 for a 30-day supply ($60 per 60-day supply or $90 per 90-day supply) per prescription insulin drug, regardless of the amount or type of insulin needed to meet the customer’s insulin needs.

SCHEDPHARM90-kyet

Prescription Drug Benefits

Limitations

Prescription Eye Drops

For prescription eye drops, an early refill will be allowed if the prescribing practitioner indicates on the original prescription that additional quantities are needed and the refill you request does not exceed the number of additional quantities prescribed. Coverage for one additional bottle of prescription eye drops limited to one bottle every three months if needed for daycare or school.

Supply Limit Exceptions

For non-controlled substances, call member services to find out what the supply policy exceptions are, if you need to refill a prescription before your current supply ends.

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or

specified in the “Home Health Care Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.

- membership costs and fees associated with health clubs, weight loss programs or smoking cessation programs not recommended by the U.S. Preventive Services Task Force.
- all nutritional supplements, formulae, enteral feedings, supplies and specialty formulated medical foods whether prescribed or not, except for infant formula needed for the treatment of inborn errors of metabolism; except for 100% human milk fortifiers for the prevention of Necrotizing Enterocolitis.

Termination of Insurance

Special Continuation of Medical Insurance

For Employees and Dependents

If your Medical Insurance would cease and if you have been insured for at least three consecutive months under this policy or a policy it replaces, upon payment of the required premium by you to your Employer, your Medical Insurance will be continued until the earliest of:

- 18 months from the date Medical Insurance would otherwise cease;
- the last day for which you have paid the required premium;
- the date you become eligible for insurance under another group policy for medical benefits or under Medicare;
- for a Dependent, the date that Dependent no longer qualifies as a Dependent;
- the date the policy cancels.

Your Employer will notify you in writing of your right to elect such continuation by sending you an election of continuation of coverage form, samples of which have been provided by the Insurance Company.

Within 31 days after the date notice was sent to you, you may elect such continuation in writing by returning the election of continuation of coverage form and paying the required premium.

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 pas1.8899.33600044 Tm 9 that8gcm B a Cignr

[redacted]

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
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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 >2sormise aCre

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

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.

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

standards of the profession of the health care provider rendering the service, the procedure is Medically Necessary

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.

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.

For charges made for Substance Use Disorder, 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-

- 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.
-

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
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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
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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.

which injections, infusions, and implantable drugs are subjhich i0u

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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

[redacted]

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

- 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.

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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
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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
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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.

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Important Notice

A person who is covered under this plan may submit a written request to Cigna for:

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

HC-IMP392 01-24
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- diabetes self-management training at initial diagnosis, and at significant changes in symptoms, conditions, or treatment.

HC-COV1493 01-24
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Durable Medical Equipment

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, ventilators, insulin pumps and wheel chairs. This includes the following diabetic equipment not subject to any Durable Medical Equipment deductible or maximum: insulin pumps, blood glucose monitors and blood glucose monitors for the legally blind.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- Bed Related Items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- Bath Related Items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- Fixtures to Real Property: ceiling lifts and wheelchair ramps.
- Car/Van Modifications.
- Air Quality Items: room humidifiers, vaporizers and air purifiers.
- Other Equipment: centrifuges, needleless injectors, heat lamps, heating pads, cryounits, cryotherapy machines, ultraviolet cabinets that emit Ultraviolet A (UVA) rays, sheepskin pads and boots, postural drainage board, AC/DC

treatment of the prescribed indication in any one of the

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; and
- For treatment of diabetes: non-experimental medication for controlling blood sugar, medication used in the treatment of the feet, ankles or nails associated with diabetes, insulin, pre-filled insulin pens and cartridges, insulin pump accessories (excluding insulin pumps), glucose test strips, visual reading and urine testing strips, lancets and spring-powered lancet devices, syringes.

HC-DFS1959 01-24
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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
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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.

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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 ngs1.67800903 cm BT TJ EduC3.809ant 0 53.1959

- 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 screening prostate-specific antigen (PSA) testing.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- 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.

Autism

Charges for diagnosis and treatment of Autism Spectrum Disorders for a covered child 18 years of age or younger. 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, tracetvotl Cesepns etrainin1(ng, incentive dit)1(rvint on irograms1(s)-1(, i

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- 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.

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 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.

Virtual Care

Dedicated Virtual Providers

Includes charges for the delivery of medical and health-related services, consultations, and remote monitoring by dedicated virtual providers as medically appropriate through audio, video and secure internet-based technologies.

Virtual Physician Services

Includes charges for the delivery of 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.

Behavioral consultations and services via secure telecommunications technologies that shall include video capability, including telephones and internet, when delivered through a behavioral provider.

Enteral Nutrition

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

- 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.
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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.

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Covered Expenses

- charges for Medically Necessary biomarker testing for the diagnosis, treatment, appropriate management, and ongoing monitoring of cancer when biomarker testing is supported by medical and scientific evidence.
- charges for testing, treatment, and prevention of sexually transmitted disease.
- charges for Medically Necessary treatment of conditions related to gender dysphoria and gender incongruence.
- 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-COV1408 01-24
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Limitations

Step Therapy

Certain Prescription Drug Products are subject to step therapy

Important Information

Rebates and Other Payments

Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals covered under your plan and Prescription Drug Products included on the Prescription Drug List.

As required by law, Cigna or its affiliates must use rebates or other remuneration from pharmaceutical manufacturers to either reduce your Deductible, Coinsurance, or Copayment that you pay at the point-of-sale for Medical Pharmaceuticals covered under your plan and Prescription Drug Products included on the Prescription Drug List or apply such amounts to reduce the cost of future premiums.

HC-IMP437 01-25
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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 m 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 n339995plly covered by Medicare or Medicaid sh995pll also be inc95pluded 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, inc95pluding the 9995pnner 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 institut of 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 pla95pnning 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 represent995pt ves 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 con13399nce 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 con1idential treatment of all information contained in the patient's personal and clinical record, inc95pluding that stored in an automatic dat a anknd

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

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

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[redacted]

Enteral Nutrition

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

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.

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).

- 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

- 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

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage critr. Coga ierioerage for certain PresJ 1 0t-ptio8tion Drug Pr02

[redacted]

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-PHR649 01-24
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-PHR721 01-24
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,

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:

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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

- 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 i.e. prior to the 48 or 96

- 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;

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;
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HC-DFS1526 ET

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

CERTIFICATE RIDER – Pennsylvania Residents

Rider Eligibility: Each Employee who is located in Pennsylvania

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.

Definitions

Dependent

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

HC-DFS1675 01-22
ET

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:

- insulin;
- injection aids;
- pre-filled insulin pens and cartridges;
- pharmacological agents for controlling blood sugar.
- needles and syringes for self-administered medications or Biologics covered under the plan's Prescription Drug benefit; and
- inhaler assistance devices and accessories, peak flow meters.

HC-DFS1676 01-22
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

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:

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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.

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.

HC-EXC544 02-24
ET

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.

The Schedule

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

The Nutritional Counseling 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.”

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Covered Expenses

- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage on oral contraceptives.
- 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 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 one mammogram for women age 35 to 39; one mammogram every two years for women age 40 to 49; and an annual mammogram for women age 50 and older.
- charges for an annual Pap smear, and 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
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effective date will be based on: class of risk and age; and benefits.

- 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.

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.

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.

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

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 m] TJ 1 or servig

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:
  -

- 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

[redacted]

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

The Schedule

The Medical Schedule is amended to add the provision “Hearing Aids”:

Hearing Aids

No charge at least $3,000, per ear with hearing loss, every 36 months, or the client’s elected amount, whichever is greater. Costs exceeding the coverage amount are subject to the applicable deductible and coinsurance.

SCHED WA ET7

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

[redacted]

section for information regarding coverage or oral contraceptives.

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-COV1630 01-25

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The Schedule

The Pharmacy Schedule is amended to add the provision “Abortion Drugs”:

Abortion Drugs

Coverage of abortion prescription drugs will not be subject to costshare after your plan deductible is met.

SCHEDPHARM90-waet3

The Schedule

The Pharmacy Schedule is amended to add the provision “Epinephrine Auto-Injector Device”:

Epinephrine Auto-Injector Device

Your costshare for a covered epinephrine auto-injector device will not exceed $35 for a 30-day supply after your plan deductible is met.

SCHEDPHARM90-waet4

The Schedule

The Pharmacy Schedule is amended to add the provision “Prescription Asthma Inhaler”:

Prescription Asthma Inhaler

Your costshare for a covered prescription asthma inhaler will not exceed $35 for a 30-day supply.

SCHEDPHARM90-waet5

The Schedule

The Pharmacy Schedule is amended to add the provision “HIV Post-Exposure Prophylactic Drugs”:

HIV Post-Exposure Prophylactic Drugs

Coverage of human immunodeficiency virus (HIV) post-exposure prophylactic drugs prescribed after a possible exposure to HIV will not be subject to costshare after your plan deductible is met.

SCHEDPHARM90-waet6

The Schedule

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 and counts toward

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;
-

If the information provided is not sufficient to approve or deny

demonstrated to be associated with an adverse effect that is a result of receiving the investigational product.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician relies on the coverage policies maintained by Cigna or the Review Organization. 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. Charges for health care services, supplies, or medications when billed for conditions or diagnoses that are not covered or reimbursable under the coverage policies maintained by Cigna or the Review Organization.

With regard to a life-threatening illness, the plan or policy shall not deny coverage for a drug, Biologic therapy or device as experimental, investigational and unproven if the drug, Biologic therapy or device is otherwise (a) approved by the FDA to be lawfully marketed and is recognized for treatment of the prescribed indication in any one of the following: U.S. Pharmacopeia Drug Information; American Medical Association Drug Evaluation; American Hospital Formulary Service; other compendia identified by state or federal government; the majority of related peer-reviewed medical literature; or the Federal Secretary of Health & Human Services; (b) the drug has been otherwise approved by the FDA; and (c) the drug has not been contraindicated by the FDA for the off-label use prescribed.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem. Cosmetic surgery and therapy does not include gender affirmation services.
- aids or devices or other adaptive equipment that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- all nutritional supplements, formulae, enteral feedings, supplies and specially formulated medical foods, whether prescribed or not, except for infant formula needed for the treatment of inborn errors of metabolism and as specifically provided in the “Enteral Nutrition” benefit.
- charges for abortion services.

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
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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

Prescription Drug Product

- The following diabetic supplies: insulin, syringes, injection aids, blood glucose monitors, test strips, prescription oral agents for controlling blood sugar, glucagon emergency kits.

HC-DFS2089 01-25
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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.

HC-FED100 01-24
V2-ET