

University of New England

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2024

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3345889

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

Printed in U.S.A.

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

CERTIFICATE RIDER

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

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

IMPORTANT INFORMATION

For Residents of States other than the State of Maine:

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

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

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

- (a) Benefit plans made available to you and/or your Dependents by your Employer;
 - (b) Benefit plans for which you and/or your Dependents are eligible;
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- the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

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

Examples of routine patient care costs and services include:

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

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

- In-Network providers are not participating in the clinical trial; or

- The clinical trial is conducted outside the individual's state of residence.

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

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

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

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



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

HC-EXC475

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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.

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Definitions

Dependent

Dependents include:

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

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Emergency Service Provider

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

HC-DFS236

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Employee

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

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Employer

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

HC-DFS1594

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

CERTIFICATE RIDER – Connecticut Residents

Rider Eligibility: Each Employee who is located in Connecticut

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

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



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



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

CERTIFICATE RIDER – Florida Residents

Rider Eligibility: Each Employee who is located in Florida

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

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

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

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

HC-ETFLRDR

Eligibility - Effective Date

provisions in your certificate including **the provisions of the certificate that apply to you**



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- charges made for medical, surgical and Hospital care during



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

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Termination of Insurance

Special Continuation of Medical Insurance For Dependents of Military Reservists

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

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

Reinstatement of Medical Insurance - Employees and Dependents

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

Provisions Applicable to Reinstatement

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

Conversion Available Following Continuation

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

Medical Benefits Extension Upon Policy Cancellation

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

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

Totally Disabled

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

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

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

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

HC-BEX42

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Definitions

Dependent – For Medical Insurance

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided

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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

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

Virtual Care

Virtual Physician Services

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

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

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

Includes bundled health care services delivered through a



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

Partial Hospitalization and Outpatient Facility

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

SCHEDMD-ET1

The Schedule

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

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

SCHED MD

ET-24

Covered Expenses

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

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

community health nursing with an emphasis on maternal and child health; and include any services required by the attending provider.

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

Additionally, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn also remain in the Hospital, coverage will be provided for additional hospitalization for the newborn for up to four days.

- charges for inpatient or outpatient expenses for orthodontics; oral surgery; and otological, audiological and speech/language treatment involved in the management of cleft lip or cleft palate or both.
- charges made for testing of bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis when the bone mass measurement is requested by a health care provider for a qualified individual. A “qualified individual” means: an estrogen-deficient individual at clinical risk for osteoporosis; an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease; an individual receiving long-term glucocorticoid (steroid) therapy; an individual with primary hyperparathyroidism; or an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

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Clinical Trials

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

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

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

HC-BEX4

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V1-ET

Definitions

Sickness – For Medical Insurance

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

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

CERTIFICATE RIDER – Massachusetts Residents

Rider Eligibility: Each Employee who is located in Massachusetts

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

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

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

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

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

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

Your Rights Under Mental Health Parity

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

Complaints Concerning Non-Compliance With Mental Health Parity

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

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

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



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

Substance Abuse

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

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

SCHEDMA-ET1

Covered Expenses

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

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

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

Excluding any charges for:

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

Approximate Intervals are:

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

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



treatment of speech, hearing and language disorders in a

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

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

Psychopharmacological services and neuropsychological

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

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

Outpatient Services

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

- In-home therapy is Medically Necessary therapeutic clinical intervention or ongoing training, as well as therapeutic support; provided however, that the intervention or support shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting.
- In-home behavioral services are a combination of Medically Necessary behavior management therapy and behavior management monitoring; provided, however, that such services shall be available, when indicated, where the child

resides, including in the child's home.

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.

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External Prosthetic Appliances and Devices

Scalp Hair Protheses

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



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

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

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

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

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

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

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

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

- Medical Pharmaceutical regimens that have a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s);

- Medical Pharmaceuticals newly approved by the Food & Drug Administration (FDA dger the pla33600044 Tm 0003TJ30 -vln



Termination of Insurance – Continuation

Medical Insurance for Former Spouse



- 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

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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.

HC-ETMIRDR

Important Notices

Managed Care Disclosure

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

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

HC-IMP91

04-10
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The Schedule

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

Out-of-Network Emergency Services Charges

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

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



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

The medical schedule is amended to add the following paragraph:

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

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

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

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

Cigna, as a condition of coverage may:

- require a review of the treatment consistent with current protocols and may, at its own expense, require a review of the Treatment plan;
- request the results of the Autism Diagnostic Observation Schedule that has been used in the diagnosis of an Autism Spectrum Disorder;
- request that the Autism Diagnostic Observation Schedule be used if you do not have a current diagnosis of Autism Spectrum Disorder.

SCHEDMI-ETC

The Schedule

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

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

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

SCHEDDENE-ET1

Covered Expenses

Autism Spectrum Disorder

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

Medical Pharmaceuticals

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

HC-COV1239

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Prescription Drug Benefits

Limitations

Prescription Eye Drops Refills

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

- (a) For a 30-day supply, once 23 days have passed after either of the following:
 - The original date the prescription was distributed to you.
 - The date the most recent refill was distributed to you.
- (b) The prescriber indicates on the original prescription that additional quantities are needed.
- (c) The prescription eye drops prescribed by the prescriber are covered under the plan.

HC-PHR375

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

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

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for Q q 1 0rfective for Q q hroud by2 0 16d;devices that



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

HC-EXC490

01-22



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

Down Syndrome

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

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

Habilitative and rehabilitative care includes Medically Necessary interactive therapies derived from evidence-based

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

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

HC-COV601

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Transplant Services and Related Specialty Care

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

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung,

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



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

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

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

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

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

Overinsured

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

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

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

Converted Policy

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

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you

may convert. If you are not Entitled to Convert and your spouse and children are Entitled to Convert, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy, combined with your existing individual health insurance policy, will be issued to you.



Covered Expenses

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

HC-COV1225

01-22

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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



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

CERTIFICATE RIDER – New Hampshire Residents

Rider Eligibility: Each Employee who is located in New Hampshire

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably

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

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

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

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

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

(D) Visitors are noncompliant with written hospital policy.

- charges made for the professional services associated with the practice of fitting, dispensing, service or sale of hearing instruments or hearing aids by a hearing instrument dispenser or other hearing care professional. Coverage includes the cost of a hearing aid for each ear, as needed, as well as related services necessary to assess, select, and fit the hearing aid. An insured person may choose a higher-priced hearing aid, and pay the difference in the cost. Hearing aids must be described and dispensed by a licensed audiologist or hearing instrument specialist.
- charges for or in connection with mammograms for breast cancer screening or diagnostic purposes not to exceed: one baseline low-dose mammogram, including 3-D tomosynthesis mammography for women ages 35 to 39 years of age; a mammogram every one to two years for women 40 to 49 years of age, even if no symptoms are present; and one annual mammogram for women age 50 and over.
- charges for the treatment of cancer by autologous bone marrow transplants, which follows the protocols reviewed and approved by the National Cancer Institute.
- charges for laboratory fee expenses arising from human leukocyte antigen testing (also referred to as histocompatibility locus antigen testing) for utilization in bone marrow transplantation, up to \$150. The testing facility may not bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a covered person or a person acting on behalf of a covered person for any portion of the laboratory fee expenses.
- charges for 48 hours inpatient stay following a vaginal delivery or 96 hours following a cesarean section. An earlier discharge may be determined by the mother and attending Physician. An additional length of stay will be covered if deemed Medically Necessary.
If discharge is prior to the 48/96 hours, at least 2 postpartum visits will be provided if the service is by a licensed Physician with experience in perinatal care. Postpartum visits shall include a physical assessment of mother and infant. The assessment shall include but not be limited to: infant nutrition and feeding, infant behavior, family interactions, safety and injury prevention, infant and maternal health promotion, and community resources. Providers of postpartum visits shall be licensed health care providers experienced in perinatal care.
- charges for Medically Necessary prenatal and/or postpartum homemaker services when a woman is confined to bed rest or her daily activities are restricted by her provider.
- charges being provided in a licensed health care facility or at home and within the scope of practice of a certified midwife.
- charges made by a Hospital or an Ambulatory Surgical Facility for general anesthesia administered by a licensed anesthesiologist or anesthesiologist for dental procedures for: a child under the age of 13 who is determined by a licensed dentist in conjunction with a licensed Physician to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in an Ambulatory Surgical Facility or Hospital setting; or an individual with a developmental disability or exceptional medical circumstances, as determined by a licensed Physician, which place the person at serious risk.

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

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

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

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

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

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Covered Expenses

Mental Health and Substance Use Disorder Services

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

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

Inpatient Mental Health Services

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

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

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

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

Outpatient Mental Health Services

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

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

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



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

medically supervised artificial insemination over a one-year period; and

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

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

However, the following are specifically excluded infertility services:

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

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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



Hormonal Contraceptive Drugs

A pharmacist will be allowed to dispense Hormonal



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.
-



Payment of Benefits

Assignment and Payment of Benefits

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

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Continuation of Coverage Under New Hampshire State Law

Continuation of Medical Insurance – Employee

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

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

Continuation of Medical Insurance -- Disabled Individuals

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

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

Continuation of Medical Insurance – Former Spouse

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

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

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

Continuation of Medical Insurance -- Dependent

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

For a Dependent child:

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

For a spouse who is under age 55:

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



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

For a spouse who is age 55 or over:

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

Notification and Election

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

Continuation of Medical Insurance – Group Plan Termination

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

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

Notification and Election

If the group plan terminates because of nonpayment of group premium, Cigna will notify you of your right to continue coverage within 30 days after the termination date.

Termination of the group plan for nonpayment of premium will not occur before the expiration of any required grace

will not group



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

HC-BEX29

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Definitions

Dependent

Dependents include:

- your lawful spouse of the same or opposite sex.

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

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

HC-DFS1731

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Dependent – Applies to Vision Only

Dependents include:

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

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

HC-DFS298

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Emergency Medical Condition

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

bodily functions; or serious dysfunction of any bodily organ or part.

HC-DFS1750

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Physician

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

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

HC-DFS258

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Primary Care Physician

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

HC-DFS1753

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

CERTIFICATE RIDER – New York Residents

Rider Eligibility: Each Employee who is located in New York

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

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

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

HC-ETNYRDR

SECTION X. Additional Benefits, Equipment and Devices

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

Enteral Nutrition

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

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

SECTION XI. Inpatient Services

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

A. End of Life Care.

If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided



Prescription Drug Benefits

Exclusions

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



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

HC-ETOHRDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

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

HC-ELG256

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Covered Expenses Under the Medical Plan

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

- charges for any medical services necessary to administer prescribed off-label drugs. Coverage includes Medically Necessary services associated with the administration of the drug.

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

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

Maternity

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

Inpatient care will include:

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

Post-discharge Follow-up

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

Follow-up services will include:

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



Specialty Prescription Drug Products

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

HC-PHR569

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Payment of Benefits

Recovery of Overpayment on a Provider Claim

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

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

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

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

HC-POB149

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Medical Conversion Privilege

For You and Your Dependents

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

A Converted Policy will be issued on a direct-payment basis by Cigna only to a person who is Entitled to Convert, and only

if he applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

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

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

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

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to



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

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

Converted Policy

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

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

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

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered Under the Medical Plan

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

HC-EXC492

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Termination of Insurance

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

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

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

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



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

HC-ETRIRD

Important Notices

Rhode Island Mandatory Civil Unions Endorsement For Health Insurance

Purpose:

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

Definitions, Terms, Conditions And Provisions

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

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

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

Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family

relationships created by a civil union established according to Rhode Island law.

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

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

Caution: Federal Rights May Or May Not Be Available

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

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

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Home Health Care Services

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

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

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

Covered services include:

- skilled nursing services provided by a Registered Nurse (RN); Licensed Practical Nurse (LPN);

Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse (APRN).

- services provided by health care providers such as physical therapist; occupational therapist and speech therapist.
- services of a home health aide when provided in direct support of those Nurses and health care providers.
- necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.

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

The following are excluded from coverage:

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

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

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Cigna will have discretion to seek such recovery



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.

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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.

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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



health service provider, please call the State Health Department at 800-525-0127.

Notice Regarding Coordination of Benefits

If you are covered by more than one health benefit plan and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.

CAUTION: All health plans have timely claims filing requirements. If you or your provider fails to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delay in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

American Indian Health Services

American Indians, who are covered by this plan, may use the services of the Indian Health System under the same terms and conditions as an insured who uses in-network benefits and services.

Pharmacy Disclosures

Your Prescription Drugs Rights

You have the right to safe and effective pharmacy services. You also have the right to know what drugs are covered by your plan and the limits that apply. If you have a question or concern about your prescription drug benefits, please contact Cigna at the phone number on the back of your ID card or visit www.cigna.com/product-disclosures, under Washington or visit www.mycigna.com. If you would like to know more about your rights or if you have concerns about your plan, you may contact the Washington state office of insurance commissioner at 1-800-562-6900 or www.insurance.wa.gov. If you have a concern about the pharmacists or pharmacies serving you, please contact the Washington state department of health at 360-236-4700, www.doh.wa.gov, or HSQACSC@doh.wa.gov.

1. The Prescription Drug coverage provided by this plan uses the following provisions in the administration of coverage:
 - Exclusion of certain Prescription Drug Products from the Prescription Drug List;
 - Therapeutic drug substitution;
 - Incentives for use of generic drugs; such as step-therapy requirements and cost share incentives;

- Prior authorization requirements;
- Prescription Drug List changes;
- Supply limit requirements; and
- Specialty Prescription Drug Product requirements.

These provisions are explained in the **Prescription Drug Benefit** section of this certificate.

2. The **Prior Authorization Requirements** section of this certificate explains the process that you and your Physician must use to seek coverage of a Prescription Drug Product that is not on the Prescription Drug List or is not the preferred Prescription Drug Product for a covered medical condition.
3. You may be eligible to receive an emergency fill for a Prescription Drug Product at a non-Network Pharmacy if Cigna determines that the Prescription Order could not reasonably be filled at a Network Pharmacy. Your payment will be based on the Usual and Customary Charge submitted by the non-Network Pharmacy. You also may be eligible to receive an emergency fill for a Prescription Drug Product while a prior authorization request is being processed. The process for requesting this emergency fill and the cost share requirements for this emergency fill are described in the **Prescription Drug Benefit, Medication Synchronization and Emergency Fills Medication** section of this certificate.
4. The **Prescription Drug List Management and New Prescription Drug Products** sections in the **Prescription Drug Benefits** section of this certificate explain the process for developing coverage standards and the Prescription Drug Lists.
5. The **Prescription Drug List Management and New Prescription Drug Products** sections in the **Prescription Drug Benefits** section of this certificate explain the process for changing coverage standards and the Prescription Drug Lists. Additionally, the



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.

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Discrimination is Against the Law

Cigna complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422



If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at:



**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

- charges made for general anesthesia services and related facility charges in conjunction with any dental procedure performed in a Hospital or Free-Standing Surgical Facility if such anesthesia services and related facility charges are Medically Necessary because the covered person:
 - is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
 - has a medical condition that the person's Physician determines would place the person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the person's Physician.
- charges for Medically Necessary donor human milk in accordance with the Washington State requirements for inpatient use when ordered by a licensed health care provider with prescriptive authority or an international board certified lactation consultant certified by the international board of lactation consultant examiners for an infant who is medically or physically unable to receive maternal human milk or participate in chest feeding or whose parent is medically or physically unable to produce maternal human milk in sufficient quantities or caloric density or participate in chest feeding.
- charges made for orally administered anti-cancer medication prescribed to kill or slow cancer cell growth are paid at the same cost share as intravenous or injectable anti-cancer drugs.
- charges for the treatment for insulin using diabetes, non-insulin using diabetes, or elevated blood glucose levels induced by pregnancy, including:
 - diabetes equipment including blood glucose monitors, insulin pumps and accessories, insulin infusion devices, foot care appliances for prevention of complications associated with diabetes;
 - diabetes outpatient self-management training and education.
- charges made for ABA therapy.
- charges made for acupuncture.
- Gender Transition - Charges for services related to gender transition including gender reassignment surgery. Coverage when applicable includes behavioral counseling, hormone therapy, genital reconstructive surgical procedures, and initial mastectomy or breast reduction.
- Gender Transition – Additional services - charges for additional masculinization and feminization services when rendered in conjunction with treatment of gender dysphoria, including breast augmentation with or without prosthetic implant, facial feminization surgery, thyroid cartilage reduction, speech therapy, voice feminization surgery and

electrolysis epilation for the face and genitalia, when Medically Necessary.

Virtual Physician Services

Includes charges for the delivery of real-time medical and health-related services, consultations and remote monitoring as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting. Coverage includes services provided through audio only.

Enteral Nutrition

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

Coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism.



supply will not exceed \$35 dollars, per prescription.
Deductible will be waived.

If applicable, the following text that appears under **Patient Assurance Program** in your Pharmacy Schedule is amended



claim system to allow you to have coverage for those Prescription Drug Products. The length of the authorization will depend on the diagnosis and Prescription Drug Products. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Products has been approved, you can contact the Pharmacy to fill the covered Prescription Order or Refill.

If a prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Products is not authorized within forty-eight hours for an urgent care review and within 5 calendar days for a non-urgent care review.

If the information provided is not sufficient to approve or deny the claim, Cigna will, within twenty-four hours for an urgent care review request, and within 5 business days for a non-urgent care review request, request that the Physician submit additional information to make the prior authorization determination. Cigna will give the Physician forty-eight hours for an urgent care review request or 5 calendar days for a non-urgent care review request to submit the requested information. Cigna will then approve or deny the request within forty-eight hours for an urgent care review or 4 calendar days for a non-urgent care review of the receipt of the requested additional information.

Whenever there is an adverse determination resulting in a denial, Cigna will notify the requesting Physician by one or more of the following methods: phone, fax and/or secure electronic notification, and also notify you or your Dependent in writing or via secure electronic notification. The notification of the denial will include the specific reason for the denial as well as information on how to appeal the decision. Status information will be communicated to the billing Pharmacy, via electronic transaction, upon Cigna's receipt of a claim after the request has been denied. Cigna will transmit these notifications within the time frames specified above based on if the review was urgent or non-urgent and in compliance with United States Department of Labor standards. If the request was made by the Pharmacy, notification will also be made to the prescriber.

A non-urgent care review request refers to any request for approval of care or treatment where the request is made in advance of the patient obtaining medical care or services, or a renewal of a previously approved request, and is not an urgent care request.

An urgent care review request refers to any request for approval of care or treatment where the passage of time could seriously jeopardize the life or health of the patient, seriously jeopardize the patient's ability to regain maximum function or, in the opinion of a provider with knowledge of the patient's medical condition, would subject the patient to severe pain

that cannot be adequately managed without the care or treatment that is the subject of the request.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the Prescription Drug Products should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

When Cigna establishes new limitations on coverage of a Prescription Drug Product, Cigna will ensure that prior notice of the change will be provided as soon as is reasonably possible to insureds who filled a prescription for the drug within the prior three months.

If an insured agrees to receive electronic notice and such agreement has not been withdrawn, Cigna will provide either electronic mail notice or written notice by first class mail at the last known address of the insured.

If these notice methods are not available because Cigna does not have contact information for the insured, Cigna will post notice on its web site or at another location that may be appropriate.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred Prescription D-15(d)-15(u)-15(c)



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 any other USERRA 1(o) privilege, you will be reinstated to the same level of coverage as if you had not been on leave of absence.