# LCS Community Employment LLC

EXTRATERRITORIAL LEGISLATION

**EFFECTIVE DATE:** January 1, 2026

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3346369

This document printed in December, 2025 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: LCS Community Employment LLC

Rider Eligibility: Each Employee as noted within this certificate rider

Policy No. or Nos.: 3346369

Effective Date: January 1, 2026

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 Iowa:**

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

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

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

(a) Benefit plans made available to you and/or your Dependents by your Employer;

(b) Benefit plans for which you and/or your Dependents are eligible;

(c) Benefit plans which you have elected for you and/or your Dependents;

(d) Benefit plans which are currently effective for you and/or your Dependents.

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

*Alicia M. Morrow, ESQ, Corporate Secretary*

HC-ETRDR

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

**CERTIFICATE RIDER –** Alabama Residents

Rider Eligibility: Each Employee who is located in Alabama

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 Alabama for group insurance plans covering insureds located in Alabama. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETALRDR

## Covered Expenses

- charges for inpatient care for a mother and her newborn for 48 hours after a vaginal delivery and 96 hours after a caesarean section as requested by the perinatal care Physician, OB/GYN, certified nurse midwife, or the child's attending pediatrician. A length of stay beyond 48 or 96 hours will be covered if determined Medically Necessary. Early discharge will be permitted provided the requirements noted above have been met. All children are covered from birth.
- charges for a biennial mammogram for women ages 40 to 49 and an annual mammogram for women age 50 and over. Cigna standardly provides coverage for all necessary mammograms when ordered by a woman's Physician. Payment will be made for all charges related to the mammogram. Benefits will be paid the same as any other Covered Expense.

HC-COV1547 01-25

ET

## The Schedule

The following supersedes any similar provision shown in the Pharmacy Schedule:

For all insulin drugs covered by this plan your cost share amount will be capped so that the amount you are required to pay for all covered prescription insulin drugs for each 30-day supply will not exceed $100 dollars, per prescription. Deductible will be waived.

SCHEDPHARM90-alet1

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

**CERTIFICATE RIDER –** Arizona Residents

Rider Eligibility: Each Employee who is located in Arizona

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 Arizona for group insurance plans covering insureds located in Arizona. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETAZRDR

**Arizona**

**Important Notice**

This notice is to advise you that you can obtain a replacement Appeals Process Information Packet by calling the Customer Service Department at the telephone number listed on your identification card for "Claim Questions/Eligibility

Verification" or for "Member Services" or by calling 1-800-244-6224.

The Information Packet includes a description and explanation of the appeal process for Cigna.

**Provider Lien Notice**

Arizona law entitles health care providers to assert a lien for their customary charges for the care and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. If you are injured and have a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, your health care provider may assert a lien against available proceeds from any such insurer or payor in an amount equal to the difference between the sum, if any, payable to the health care provider under this Plan and the health care provider's full billed charges.

**Notice**

This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.

HC-IMP8 04-10
V1-ET

## Eligibility - Effective Date

**Reinstatement of Benefits for Military Returnees**

If your coverage ends when you are called to active duty and you are reemployed by your current Employer, coverage for you may be reinstated if you applied for reinstatement within 90 days from the date of discharge or within one year of hospitalization continuing after discharge.

HC-ELG267 03-20
ET

## Definitions

**Emergency Services**

Emergency Services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to stabilize the patient.

HC-DFS1725 01-22
ET

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

**CERTIFICATE RIDER –** Arkansas Residents

Rider Eligibility: Each Employee who is located in Arkansas

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 Arkansas for group insurance plans covering insureds located in Arkansas. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETARRDR

**Important Information**

**Rebates and Other Payments**

Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals covered under your plan and Prescription Drug Products included on the Prescription Drug List. As required by law, Cigna or its affiliates must pass 100% of the value of such rebates or other remuneration to you to reduce you Deductible, Coinsurance, Copayment that you pay at the point-of-sale for Medical Pharmaceuticals covered under your plan and Prescription Drug Products included on the Prescription Drug List. Cigna

and its affiliates must use any amounts over and above your Deductible, Coinsurance, Copayment to reduce the cost of future premiums.

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

If Cigna determines that a Pharmacy, pharmaceutical manufacturer or other third party is or has waived, reduced, or forgiven any portion of the charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Prescription Drug Product without Cigna’s express consent, then Cigna in its sole discretion shall have the right to deny the payment of plan benefits in connection with the Prescription Drug Product, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the Pharmacy, pharmaceutical manufacturer or other third party represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by the plan.

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

HC-IMP381 01-23
ET

# Important Notices

**DISCLOSURE NOTICE**

NOTICE: AS PERMITTED BY §23-79-803, THE POLICYHOLDER HAS SELECTED THIS PLAN WHICH DOES NOT PROVIDE COVERAGE IN ACCORDANCE WITH ONE, SOME OR ALL OF THE REQUIREMENTS FOR ONE OR MORE BENEFITS MANDATED BY THE STATUTES OF THE STATE OF ARKANSAS

STATE MANDATED BENEFITS NOT COVERED IN WHOLE OR IN PART ARE AS FOLLOWS:

Note: Refer to your Policy or Certificate of Insurance for details about covered expenses, non-covered expenses and limited covered expenses. Inclusion on this Disclosure Notice list may not mean that the benefit or service is not covered, but only that coverage may differ in some respect from the statutory requirements:

Arkansas Mental Health Parity Act, §23-99-501, et. Seq.

Prescription drug benefit, §23-79-149

Provisions generally, unlicensed professionals (“Freedom of Choice”) §23-79-114 and Bulletin 9-85

You are urged to contact your health insurance agent or the Arkansas Insurance Department Consumer Affairs or Legal Division about questions or concerns related to the nature of the state mandated health benefit which is not provided in this health benefits plan.

HC-IMP24 04-10
V1-ET

# Eligibility - Effective Date

## Dependent Insurance

**Exception for Newborns**

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 90 days after his birth or the next premium due date, whichever is later. If you do not elect to insure your newborn child within such 90 days or by the next premium due date, whichever is later, coverage for that child will end on the 90th day. No benefits for expenses incurred beyond the 90th day will be payable.

**Exception for Adopted Children**

Any Dependent child adopted by you while you are insured will become insured from the date the adopted child is placed with you, or from the date you file the petition for adoption, if you elect Dependent Insurance no later than 90 days from the date of the petition for adoption, or from the date of placement, whichever is later. A newborn adopted child will become insured from the moment of birth, if the petition is filed and if you elect Dependent Insurance no later than 90 days from the child’s birth.

If you do not elect to insure your adopted child within such 90 days, or if your petition for adoption is dismissed or denied, no

benefits for expenses incurred beyond the 90th day following placement or filing of the petition to adopt, whichever is later, will be payable.

HC-ELG241 01-19
ET

# The Schedule

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

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

“3 visits; the visit limit does not apply to treatment of diabetes.”

SCHED AR ET8

# The Schedule

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

**Mammograms, PSA, Pap Smear, Colorectal Cancer Screenings**

In-Network Preventive Care Related Services (i.e. “routine” services) will be covered at "100%".

SCHED AR ET3

# The Schedule

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

In-Network Preventive Care Related Services (i.e. “routine” services) will be covered at "100%".

SCHED AR ET5

# The Schedule

The provision “Mammograms, PSA, Pap Smear” in your medical schedule for PSA is amended to indicate In-Network and Out-of-Network Preventive Care Related Services (i.e. “routine” services) will not be subject any plan deductible.

SCHED AR ET4

## Covered Expenses

- charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided, including charges for Ambulance services to treat an individual in place, triage, or triage and transport to an alternative destination if the ambulance service is coordinating care through telemedicine for a medical-based complaint or a behavioral-based compliant.
- charges for screening for hepatitis C during pregnancy; not subject to Copay or Deductible.
- charges for the treatment of newborn children for congenital defects, spinal muscular atrophy, premature birth, and tests for hypothyroidism, phenylketonuria and galactosemia and tests for sickle cell anemia and all other genetic disorders for which screening is performed by or for the State of Arkansas. Coverage will also include routine nursery care and pediatric charges for well newborn children for the earlier of 5 days in a Hospital nursery, or until the mother is discharged from the Hospital.
- charges made for anesthesia, hospitalization services or ambulatory surgical facility charges performed in connection with dental procedures when such services are required to effectively perform the procedures and the patient is:
  - under seven years of age and it is determined by two dentists that treatment in a Hospital or ambulatory surgical center is required without delay due to a significantly complex dental condition; or
  - a person with a serious diagnosed mental or physical condition; or
  - a person with a significant behavioral problem as determined by their Physician.
- charges made for hearing aids, not to exceed $1,400 per ear, every three years. Coverage provided shall include: an instrument or device, including repair and replacement parts, that: is designed and offered for the purpose of aiding

individuals with or compensating for impaired hearing; is worn in or on the body; and is generally not useful to a person in the absence of a hearing impairment.

- charges for colorectal cancer examinations and laboratory tests for individuals who:
  - are 45 years of age or older.
  - less than 45 years of age and at high risk for colorectal cancer. Individuals defined to be at "high risk" include:
    - the presence of one (1) or more adenomatous polyps on a previous colonoscopy, or flexible sigmoidoscopy;
    - have a family history of colorectal cancer;
    - have genetic alterations of hereditary nonpolyposis;
    - have colon cancer or familial adenomatous polyposis;
    - a personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and
    - any additional or expanded definition of "high risk" as recognized by medical science and determined by the Secretary of the Department of Health in consultation with the University of Arkansas for Medical Sciences and consistent with guidelines issued by the United States Preventive Services Task Force.
  - individuals experiencing the following symptoms of colorectal cancer as determined by a Physician: bleeding from the rectum or blood in the stool; or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

  The colorectal screening shall involve an examination of the entire colon, including:

  - all examinations, lab tests, or preventive screening tests assigned either a grade of "A" or a grade of "B" by the United States Preventive Services Task Force.
  - any additional medically recognized screening tests determined by the United States Preventive Services Task Force for colorectal cancer.

    Benefits for follow-up screening shall be limited to the following guidelines for the management or subsequent need for follow-up colonoscopy:

    - a colonoscopy performed as a result of a positive result on a non-colonoscopy preventive screening test; or
    - any additional non-colonoscopy preventive screening tests for colorectal cancer required by the Secretary of the Department of Health in consultation with the University of Arkansas for Medical Sciences and consistent with guidelines issued by the United States Preventive Services Task Force.
- charges for prostate cancer examinations and laboratory tests once a year for non-symptomatic men who are forty years of age or older in accordance with the National Comprehensive Cancer Guidelines.
- expenses incurred at any of the Approximate Age Intervals shown below for a Dependent child who is age 18 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;
  - appropriate immunizations, which are not subject to any Copay, Coinsurance, Deductible, or dollar limit, and laboratory tests; excluding any charges for:
    - more than one visit to one provider for Child Preventive Care Services at each of the Approximate Age Intervals up to a total of 20 visits for each Dependent child;
    - services for which benefits are otherwise provided under this Covered Expenses section; and
    - services for which benefits are not payable according to the Expenses Not Covered section.

  Approximate Age Intervals are: Birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years.
- charges made for corrective surgery and related medical care for individuals of any age diagnosed as having a craniofacial anomaly, if the surgery and treatment are Medically Necessary to improve a functional impairment, as determined by a surgical member of a nationally accredited cleft-craniofacial team, approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, NC. "Craniofacial anomaly" means the abnormal development of the skull and face.

Required medical care coverage includes reconstructive surgery, dental care, and vision care. Coverage for the following is included, if Medically Necessary:

- on an annual basis:
  - sclera contact lenses, including coatings;
  - office visits;
  - an ocular impression of each eye;
  - autologous serum eye drops;
  - eye weights, either surgically and/or external eye weights in one or both eyes, as directed by an eye specialist; and
  - any additional tests or procedures that are Medically Necessary for a craniofacial patient.
- every two (2) years, two (2) hearing aids and two (2) hearing aid molds for each ear; and
- every four (4) years, a dehumidifier.

- charges for prescription drugs or devices approved by the United States Food and Drug Administration for use as a contraceptive. Cost share levels are the same as for other covered prescription drugs. Covered contraceptives include oral, implantable, and injectable contraceptive drugs, intrauterine devices, and prescription barrier methods for contraception.
- charges for a screening mammography, digital breast tomosynthesis, and breast ultrasound. Coverage includes:
  - a single baseline mammogram for women age 35 to 40;
  - annual mammograms for women age 40 and older;
  - mammograms upon Physician's recommendation, without regard to age, where there is a prior history of breast cancer, positive genetic testing, or other risk factors; and
  - a comprehensive ultrasound screening of an entire breast or breasts if a mammogram screening demonstrates heterogeneously dense or extremely dense breast tissue when the woman's primary healthcare provider or radiologist determines a comprehensive ultrasound screening is Medically Necessary.
- charges for positron emission tomography to screen for or to diagnose cancer in a patient upon the recommendation of the patient's Physician when the patient has a prior history of cancer.
- charges for a gastric pacemaker to treat gastroparesis, a neuromuscular stomach disorder in which food empties into the stomach more slowly than normal.
- charges for the necessary care and treatment of loss or impairment of speech or hearing by a licensed audiologist or speech pathologist, subject to the same benefit levels as for other illnesses. Does not include coverage for hearing instruments or devices.
- charges made by a Hospital for a minimum of 48 hours of inpatient care following a normal vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and her newborn in a licensed health care facility. Any decision to shorten the length of stay must be made by the attending physician after conferring with the mother.
- charges for screening for depression of the birth mother by a healthcare professional within the first six (6) weeks of giving birth.
- charges for biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of an individual's disease or condition to guide treatment decisions when supported by medical and scientific evidence.
- charges for at least 48 hours of inpatient care following a mastectomy. A shorter period of inpatient care may be deemed acceptable if the insured consults with the Physician and both agree it is appropriate.
- charges for screenings for behavioral health conditions and behavioral health services provided in a Hospital, outpatient clinic, Physician clinic or through telemedicine.

**Diabetes**

Charges made for Medically Necessary equipment, services and supplies when prescribed by a Physician and administered by a licensed health care professional, for the treatment of Type I, Type II and gestational diabetes. Coverage includes:

- one self-management training program per lifetime per insured; and
- additional training due to a significant change in symptoms or condition.

**Nutritional Food Products and Formulas**

Charges for nutritional food products and formulas (regardless of the method of delivery) prescribed under the direction of a Physician for individuals with medical disorders requiring specialized nutrients or formulas if:

- the formulas are prescribed as Medically Necessary;
- a provider issues a written order stating the medical food is Medically Necessary for therapeutic treatment;

- the products are administered under the direction of a Physician, and only administered under the direction of a clinical geneticist and registered dietician; and
- the cost of the formula for an individual or a family with Dependents exceeds the $2,400 per person per year income tax credit allowed under Arkansas law.

Nutritional food products and formulas include:

- low protein modified food products;
- amino-acid-based elemental formulas;
- extensively hydrolyzed protein formulas;
- formulas with modified vitamin or mineral content; and
- modified nutrient content formulas.

Medical disorders requiring specialized nutrients or formulas means the following inherited metabolic disorders involving a failure to properly metabolize certain nutrients: Nitrogen metabolism disorder; Phenylketonuria; Maple syrup urine disease; Homocystinuria; Citrullinemia; Argininosuccinic acidemia; Tyrosinemia, type 1; Very-long-chain acyl-CoA dehydrogenase deficiency; Long-chain 3-hydroxyacyl-CoA dehydrogenase deficiency; Trifunctional protein deficiency; Glutaric acidemia, type 1; 3-methylcrotonyl CoA carboxylase deficiency; Propionic acidemia; Methylmalonic acidemia due to mutase deficiency; Methlmalonic acidemia due to cobalamin A,B defect; Isovaleric acidemia; Ornithine transcarbamylase deficiency; Non-ketotic hyperglycinemia; Glycogen storage diseases; Disorders of creatine metabolism; Malonic aciduria; Carnitine palmitoyl transferase deficiency type II; Glutaric aciduria type II; and Sulfite oxidase deficiency.

**Pediatric Autoimmune Neuropsychiatric Disorders (PANS) (PANDAS)**

Coverage for off-label use of intravenous immunoglobulin, also known as "IVIG", to treat individuals diagnosed with pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection (PANDAS), or both, if the pediatric patient's Primary Care Physician, in consultation with a Arkansas licensed pediatric psychiatrist and licensed physician practicing in at least one pediatric subspecialty, determines and agrees that the treatment is necessary and follows a patient-specific treatment plan consistent with established protocols and rules developed by the Insurance Commissioner, in consultation with the Childhood Post-infectious Autoimmune Encephalopathy Center of Excellence.

HC-COV1619 01-25 ET

## Covered Expenses

**Prostheses/Prosthetic Appliances and Devices**

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

- limb prostheses;
- terminal devices such as hands or hooks;
- speech prostheses;
- facial prostheses;
- devices for athletics or recreation; and
- devices for showering or bathing.

**Orthoses and Orthotic Devices**

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.

- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

**Braces**

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

**Splints**

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- replacement due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited as follows, unless Medically Necessary or indicated by other coverage criteria:

- no more than once every 24 months for persons 19 years of age and older; and
- no more than once every 12 months for persons 18 years of age and under.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements for external prosthetic devices;
- microprocessor controlled prostheses and orthoses; and
- myoelectric prostheses and orthoses.

HC-COV1479 01-24 ET

## Covered Expenses

**Fertility Services**

- charges made for services related to:
- diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed.

Services include, but are not limited to: injectable fertility drugs which are administered or provided by a Physician; cryopreservation, storage, and thawing of embryos; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; intrauterine insemination/artificial insemination; diagnostic evaluations; assisted reproductive techniques (ART) including in vitro fertilization (IVF); and the services of an embryologist.

Oral fertility drugs are covered under the Pharmacy benefit.

Infertility is defined as:

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

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

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, donor services, and donor eggs, sperm, and embryos;
- services for fertility preservation, including harvesting, cryopreservation, and storage;
- pre-implantation genetic material and pre-implantation genetic screening (PGS/PGT-A) of parents/donors beyond what is covered by the medical plan.

HC-COV1621 01-25
ET

# Medical Conversion Privilege

### For You and Your Dependents

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

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

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

### Employees Entitled to Convert

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

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

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

### Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

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

but only if that Dependent: is not eligible for other individual insurance coverage on a guaranteed issue basis, is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice

that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

**Overinsured**

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

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

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

**Converted Policy**

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

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

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

HC-CNV28 05-14

V2-ET

## The Schedule

The provision “Coinsurance” shown in the Pharmacy Schedule is hereby replaced with the following:

**Coinsurance**

The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product dispensed by a Network Pharmacy, and it means the percentage of the benchmark price used by Cigna for a covered Prescription Drug Product dispensed by a non-Network Pharmacy, that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.

SCHEDPHARM90-aret4

# Prescription Drug Benefits

## Limitations

**Prior Authorization Requirements**

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

Prior authorization will not be required for antiretroviral drugs that are Medically Necessary for the prevention of HIV or AIDS, including HIV preexposure prophylaxis and HIV postexposure prophylaxis.

Prior authorization will not be required for medication-assisted treatment for opioid and alcohol addiction, other than a valid prescription and compliance with the medication-assisted treatment guidelines issued by the SAMH Services Administration under the U.S. Department of Health and Human Services. If a new medication becomes available and is more expensive or not shown to be more effective than current medications, prior authorization may be applied.

**Step Therapy**

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Step therapy will not be required for antiretroviral drugs that are Medically Necessary for the prevention of HIV or AIDS, including HIV preexposure prophylaxis and HIV postexposure prophylaxis.

A step therapy protocol exception shall be granted if the required prescription drug is:

- contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient;
- expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
- a patient has tried the required prescription drug while under the patient's current or previous health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
- not in the best interest of the patient, based on Medical Necessity;
- a patient is stable on a prescription drug selected by the patient's healthcare provider for the medical condition under consideration while on a current or previous health benefit plan.

A request for a step therapy protocol exception shall be granted or denied within seventy-two (72) hours of receiving the request and twenty-four (24) hours of receiving the request for urgent cases.

You may appeal the denial of a request for a step therapy protocol exception. The health benefit plan shall grant or deny the appeal within seventy-two (72) hours of receiving the appeal and within twenty-four (24) hours of receiving the appeal for urgent cases.

If a response is not received within seventy-two (72) hours of receiving the initial request or appeal and within twenty-four (24) hours of receiving the initial request or appeal for urgent cases, then such a request shall be deemed granted.

Step therapy may not be applied for a drug approved by the United States Food and Drug Administration when coverage is provided for the treatment of psychosis and serious mental illness through antipsychotic prescription drugs and metastatic cancer.

**Prescription Eye Drops**

Charges for early refills of prescription eye drops if:

- For a thirty-day supply:
  - The amount of time has passed after which a covered person should have used seventy percent (70%) of the dosage of the prescription eye drops according to a healthcare professional's instructions on the prescription; or
  - Twenty-two (22) days have passed from the original date the prescription eye drops were distributed to a covered person; or the date the most recent refill of the prescription eye drops was distributed to a covered person;
  - The healthcare professional indicates on the original prescription that additional quantities of the prescription eye drops are needed;
  - A refill request of a covered person for prescription eye drops does not exceed the number of additional quantities needed as described above; and
  - The prescription eye drops prescribed by a healthcare professional are a covered benefit under the health benefit plan of the covered person.

HC-PHR715 01-24
ET

## Prescription Drug Benefits

**Your Payments**

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

After satisfying the plan Deductible, if any, your responsibility for a covered Prescription Drug Product subject to a Copayment requirement will always be the lowest of:

- the Copayment for the Prescription Drug Product; or
- the Prescription Drug Charge for the Prescription Drug Product; or
- the Pharmacy's Usual and Customary (U&C) Charge for the Prescription Drug Product.

HC-PHR254 12-17

ET

### Exclusions

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

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

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of the prescribed indication in any one of the following: The American Hospital Formulary Service Drug Information; The National Comprehensive Cancer Network Drugs and Biologics Compendium; and The Elsevier Gold Standard's Clinical Pharmacology; or the drug has been recognized as safe and effective for treatment of that specific type of cancer in two articles from medical literature not otherwise contradicted by any one article in a similar publication; or other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the commissioner.

HC-PHR812 01-25

ET

## Exclusions, Expenses Not Covered and General Limitations

### Exclusions and Expenses Not Covered

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

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

- 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 either:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician relies on the coverage policies maintained by Cigna or the Review Organization. Coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of the prescribed indication in any one of the following: The American Hospital Formulary Service Drug Information; The National Comprehensive Cancer Network Drugs and Biologics Compendium; and The Elsevier Gold Standard's Clinical Pharmacology; or the drug has been recognized as safe and effective treatment of that specific type of cancer in two articles from medical literature not otherwise contradicted by any one article in a similar publication; or other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the commissioner.
- surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) and craniofacial muscle disorders, except as described in Covered Expenses.
- except as specified in the Covered Expenses section, hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- all nutritional supplements, formulae, enteral feedings, supplies and specially formulated medical foods, whether prescribed or not, except for formula needed for the treatment of inborn errors of metabolism.

HC-EXC625 01-25
ET

# Termination of Insurance

### Special Continuation of Medical Insurance

If your insurance would otherwise cease because of termination of employment or termination of membership in an eligible class, your Medical Insurance will be continued, upon payment of the required premium by you to your Employer, until the earliest of:

- 120 days from the date your insurance would otherwise cease;
- the last day for which you have paid the required premium;
- the date you become eligible for medical benefits under another group policy or under Medicare;
- the date the policy is canceled.

If your insurance is being continued as outlined above, the Medical Insurance for your Dependents insured on the date your insurance would otherwise cease may be continued, subject to the provisions set forth above. The Dependent Insurance will be continued until the earlier of:

- the date your insurance ceases; or
- with respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent, except in the case of change in marital status.

### Dependent Insurance After Change in Marital Status

Medical Insurance on your spouse and the eligible Dependents of that spouse, that would otherwise cease due to change in marital status, will be continued until the earliest of:

- 120 days from the date the insurance would otherwise cease due to change in marital status;
- the last day for which the required premium is paid;
- the date the person becomes eligible for medical benefits under another group policy, or under Medicare;

- the date the policy, or Dependent Insurance under it, is canceled;
- the date your insurance ceases.

If, on the day before the Effective Date of this policy, medical insurance was being continued for a person under a group medical policy sponsored by your Employer and replaced by this policy, his insurance will be continued under this policy as set forth above.

Your Employer will, within 10 days of the date your insurance would otherwise cease, notify you of your and your eligible Dependent's right to elect continuation as set forth above. You or your eligible Dependent may elect such continuation within 31 days after the date the insurance would otherwise cease, by paying the required premium to your Employer.

You and your Dependents are eligible to elect continuation of insurance only if you have been insured under this policy for 3 consecutive months immediately prior to the date insurance would otherwise cease.

**Conversion Available Following Continuation**

The provisions of the "Medical Conversion Privilege" section will apply following the termination of insurance.

HC-TRM58 04-10
V1-ET

# Medical Benefits Extension During Hospital Confinement 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 Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group plan;
- the date you or your Dependent is no longer Hospital Confined; or
- the date Hospital benefits are exhausted.

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

HC-BEX20 04-10
V1-ET

# Definitions

**Dependent**

The term child means a child born to you or a child legally adopted by you from the date you file a petition for adoption.

HC-DFS1672 01-22
ET

**Prescription Drug Charge**

The amount Cigna charges to the Plan, including the applicable dispensing fee and any applicable sales tax and prior to application of any Deductible, Copayment or Coinsurance amounts, for a Prescription Drug Product dispensed at a Network Pharmacy. Cigna may pay a Network Pharmacy a different amount for a Prescription Drug Product than the Plan pays to Cigna. You are not entitled to the difference between the rate Cigna charges to the Plan and the rate Cigna pays to the Pharmacy for a Prescription Drug Product. For the purposes of Prescription Drug benefit payments, the “Plan” is the entity or business unit responsible for funding benefits in accordance with the terms and conditions outlined in this booklet/certificate.

HC-DFS1092 12-17
ET

**Prescription Drug Product**

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

- Certain durable products and supplies that support drug therapy;
- Certain diagnostic testing and screening services that support drug therapy;
- Certain medication consultation and other medication administration services that support drug therapy;
- Certain digital products, applications, electronic devices, software and cloud-based service solutions used to predict, detect and monitor health conditions in support of drug therapy;
- Medically Necessary and appropriate diabetic supplies.

HC-DFS1892 01-24

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

**CERTIFICATE RIDER –** California Residents

Rider Eligibility: Each Employee who is located in California

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

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

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

HC-ETCARDR

**Your Rights Under HIPAA If You Lose Group Coverage**

Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. California law provides similar and additional protections. If you lose group health insurance coverage and meet certain criteria, you are entitled to purchase individual health coverage (non-group) from any health plan that sells individual coverage for hospital, medical or surgical benefits. Every health plan that sells individual health coverage for these benefits must offer individual coverage to an eligible person under HIPAA. The health plan cannot reject your application if: you are an eligible person under HIPAA; you agree to pay the required premiums; and you live or work inside the plan's service area. To be considered an eligible person under HIPAA you must meet the following requirements:

- you have 18 or more months of creditable coverage without a break of 63 days or more between any of the periods of creditable coverage or since your most recent coverage was terminated;
- your most recent creditable coverage was a group, government or church plan that provided hospital, medical or surgical benefits. (COBRA and Cal-COBRA are considered group coverage);
- you were not terminated from your most recent creditable coverage due to nonpayment of premiums or fraud;
- you are not eligible for coverage under a group health plan, Medicare, or Medicaid (Medi-Cal);
- you have no other health insurance coverage; and
- you have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA.

There are important choices you need to make in a very short time frame regarding the options available to you following termination of your group health care coverage. You should read carefully all available information regarding HIPAA coverage so you can understand fully the special protections of HIPAA coverage and make an informed comparison and

choice regarding available coverage. For more information, please call the number on your ID card.

If you believe your HIPAA rights have been violated, you should contact the CA Department of Insurance or visit the Department's web site.

HC-IMP357 01-23
ET2

## Covered Expenses

- charges made for services related to the diagnosis, treatment, and management of osteoporosis. Covered services include, but are not limited to, all FDA approved technologies, including bone mass measurement technologies as deemed Medically Necessary.
- charges made for or in connection with mammograms for breast cancer screenings or diagnostic purposes including, but not limited to: a baseline mammogram for women age 35, but less than 40; a mammogram for women age 40, but less than 50, every two years or more, if Medically Necessary and if recommended by a Physician, nurse practitioner or a nurse midwife; and a mammogram every year for women age 50 and over.
- charges for standard fertility preservation services when a covered treatment may directly or indirectly cause iatrogenic infertility. Iatrogenic is infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. As used here, 'directly or indirectly' means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine. As used here, 'standard' means fertility preservation services consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.
- charges made for a drug that has been prescribed for purposes other than those approved by the FDA will be covered if:
  - the drug is otherwise approved by the FDA;
  - the drug is used to treat a life-threatening condition or, a chronic and seriously debilitating condition and the drug is Medically Necessary to treat that condition;
  - the drug has been recognized for the treatment prescribed by any of the following: the American Hospital Formulary Service Drug Information, one of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology; The National Comprehensive Cancer Network Drug and Biologics compendium; The Thomson Micromedix Drug Dex; or two articles from major peer reviewed medical journals that present data supporting the proposed use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

HC-COV1019 01-23
ET1

### Clinical Trials

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

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

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

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

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

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

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

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

Examples of routine patient care costs and services include:

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

HC-COV884 01-20
ET

## Definitions

**Dependent**

Dependents are:

- your Domestic Partner;

The term child means a child born to you, a child legally adopted by you from the date the child is placed in your physical custody prior to the finalization of the child's adoption, or a child supported by you pursuant to a court order (including a qualified medical child support order). It also includes a stepchild or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

HC-DFS1833 01-23
ET1

## Definitions

**Domestic Partner**

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

HC-DFS1024 10-16
ET

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

**CERTIFICATE RIDER –** Connecticut Residents

Rider Eligibility: Each Employee who is located in Connecticut

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

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

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

HC-ETCTRDR

**Important Information**

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

**Coupons, Incentives and Other Communications**

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

HC-IMP265 08-19
V1 ET

## Covered Expenses

- charges for advanced radiological imaging, including for example CT Scans (including but not limited to coronary calcium scans), MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.

**Craniofacial Disorders**

Coverage for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders shall be provided for individuals 18 years of age or younger, if such processes and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association. No coverage shall be provided for cosmetic surgery.

HC-COV1565 01-24
ET3

# 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 either:

  - not approved by the U.S. Food and Drug Administration (FDA) (other than a successfully completed phase III clinical trial of the FDA), or other appropriate regulatory agency to be lawfully marketed for any indication; or

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician relies on the coverage policies maintained by Cigna or the Review Organization. Coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed and is recognized for the treatment of cancer in any one of the following: the U.S. Pharmacopeia Drug Info. Guide for the Health Care Professional; the American Medical Association (AMA) Drug Evaluations; or the American Society of Health-System Pharmacist's American Hospital Formulary Drug Service Information. Peer-reviewed medical literature means a published study in a journal or other publication in which original manuscripts have been critically reviewed for scientific accuracy, validity, and reliability by unbiased international experts, and that has been determined by the International Committee of Medical Journal Editors to have met its Uniform Requirements for Manuscripts Submitted to Biomedical Journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or any carrier that delivers, issues for delivery, renews, amends or continues a health insurance policy in this state.

- surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) and craniofacial muscle disorders (other than treatment of craniofacial disorders for individuals 18 years of age or younger, as described in Covered Expenses).

HC-EXC603 01-24

ET3

# Definitions

**Dependent**

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

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

HC-DFS1673 01-22

ET3

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

**CERTIFICATE RIDER –** Delaware Residents

Rider Eligibility: Each Employee who is located in Delaware

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 Delaware group insurance plans covering insureds located in Delaware. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETDERDR

## The Schedule

Charges for wigs (for hair loss due to alopecia areata) are payable at 100% up to an annual maximum of $500.

SCHEDDE-ET2

## The Schedule

The provision “Durable Medical Equipment” in your medical schedule is amended to include the following note:

**Note:**
Medically Necessary Insulin pumps are covered at no charge.

SCHED DE ET3

## Prior Authorization/Pre-Authorized

Coverage includes immediate access, without Prior Authorization, to a 5-day emergency supply of covered, prescribed medications for the Medically Necessary treatment of serious mental illnesses and Drug and Alcohol Dependencies, where an Emergency Medical Condition exists. The emergency supply requirement includes prescribed medications for opioid overdose reversal that are otherwise covered under the health benefit plan.

HC-PRA44 01-22
V2-ET

## Covered Expenses

- charges made for or in connection with one baseline lead poison screening or testing. Charges also include lead poison screening, testing, diagnostic evaluations, screening and testing supplies, and home visits for Dependent children who are at high risk for lead poisoning according to guidelines and criteria set by the Division of Public Health.
- charges for hearing loss screening tests of newborns and infants provided by a Hospital before discharge.
- charges for Ambulance transportation and associated basic life support (BLS) services provided by a volunteer Ambulance company.
- charges for scalp hair prostheses worn for hair loss due to alopecia areata.

HC-COV1595 01-25
ET

### Serious Mental Illness

Charges for diagnosis and treatment of Serious Mental Illness (“biologically based”) will be payable at the same rate as for other illnesses. Any Mental Illness maximums in The Schedule and any Full Payment Area exceptions for mental illness will not apply to Serious Mental Illness.

HC-COV1596 01-25
ET

## The Schedule

The following supersedes any similar provision shown in the Pharmacy Schedule:

**Prescription Insulin Drugs**

Your cost share for each prescription insulin drug will not exceed $100 for a 30-day supply, $200 for a 60-day supply, or $300 for a 90-day supply regardless of the amount or type of insulin needed to fill the prescription during that interval.

SCHEDPHARM90-deet1

## The Schedule

The Pharmacy Schedule is amended to add the provision “Diabetic Equipment & Supplies”:

**Diabetic Equipment & Supplies**

Your cost share for Medically Necessary diabetic equipment or supplies will not exceed $35 for a 30-day supply, regardless of the amount or type of diabetic equipment or supplies needed to fill the prescription during that interval.

SCHEDPHARM90-deet2

# The Schedule

The pharmacy Schedule is amended to indicate the following:

You may receive coverage for up to a 90-day supply of a covered Prescription Drug Product dispensed by a Retail Network Pharmacy or a Home Delivery Network Pharmacy. The amount you pay for a up to 90-day supply of a Prescription Drug Product at a Retail Network Pharmacy or a Home Delivery Network Pharmacy will be 3X the Copay for a 30-day supply at a Retail Network Pharmacy.

If Specialty Drugs are limited to a 30-day supply at a Home Delivery Network Pharmacy then the following will apply:

Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill and are subject to the same Copayment or Coinsurance that applies to Retail Pharmacies.

SCHED90EQ-deet

# Prescription Drug Benefits

## Limitations

### Epinephrine Injectors

Coverage will be provided for at least one formulation of Medically Necessary Epinephrine Autoinjectors on the lowest tier of the drug formulary. ‘Epinephrine Autoinjector’ means a single-use device used for the automatic injection of a premeasured dose of epinephrine into the human body.

HC-PHR787 01-25
ET2

# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs other than for scalp hair prostheses worn due to alopecia areata.

HC-EXC608 01-25
ET

# Definitions

### Drug and Alcohol Dependencies

Drug and Alcohol Dependencies means Substance Abuse Disorder or the chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances as identified in Delaware law.

HC-DFS1052 11-17
ET

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

**CERTIFICATE RIDER –** District of Columbia Residents

Rider Eligibility: Each Employee who is located in District of Columbia

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 District of Columbia group insurance plans covering insureds located in District of Columbia. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETDCRDR

# The Schedule

The medical schedule is amended to add the following “Diabetic Devices” provision.

**Diabetic Devices**

Your cost share for Medically Necessary diabetic devices and diabetic ketoacidosis devices will not exceed $100 for each

30-day supply; $200 for each 60-day supply; or $300 for each 90-day supply regardless of the amount or type of devices needed to fill each prescription during that interval.

SCHED DC ET2

# The Schedule

The "Nutritional Counseling" annual maximum shown in your medical schedule is amended to indicate the following:

"3 visits; the visit limit does not apply to treatment of diabetes"

SCHED DC ET3

## Certification Requirements

**For You and Your Dependents**

**Pre-Admission Certification/Continued Stay Review for Hospital Confinement**

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

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

HC-PAC44 12-15
ET1

## Covered Expenses

- charges made for screening prostate-specific antigen (PSA) testing.
- charges made for diabetic services for insulin-using diabetes, non-insulin-using diabetes and gestational diabetes subject to the limits as shown in The Schedule. Diabetic devices and diabetic ketoacidosis devices, services and supplies including glucometers; blood glucose monitors for the legally blind; insulin pumps; infusion devices and related accessories, including those adaptable for the legally blind; podiatric appliances; and glucagon emergency kits.
- charges for the equipment, supplies and other outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes if prescribed by a qualified health care professional authorized to prescribe such items.
- charges for insulin; syringes; prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips and urine test strips; and injection aids (i.e. lancets, alcohol swabs).
- charges for colorectal cancer screening, in accordance with the American Cancer Society colorectal cancer screening guidelines.

HC-COV1616 01-24
ET2

**Mental Health and Substance Use Disorder Services**

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

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

**Inpatient Mental Health Services**

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

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

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians;

provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

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

**Outpatient Mental Health Services**

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

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

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

**Inpatient Substance Use Disorder Rehabilitation Services**

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

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

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

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

**Outpatient Substance Use Disorder Rehabilitation Services**

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

Substance Use Disorder Partial Hospitalization Services are rendered no less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

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

**Substance Use Disorder Detoxification Services**

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

**Exclusions**

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

- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

HC-COV481 12-15

## The Schedule

The pharmacy schedule is amended to add the following:

**Prescription Insulin Drugs**

Your cost share for each prescription insulin drug will not exceed $30 for each 30-day supply; $60 for each 60-day supply; or $90 for each 90-day supply regardless of the amount or type of insulin needed to fill each prescription during that interval.

**Diabetic Devices**

Your cost share for Medically Necessary diabetic devices and diabetic ketoacidosis devices will not exceed $100 for each 30-day supply; $200 for each 60-day supply; or $300 for each 90-day supply regardless of the amount or type of devices needed to fill each prescription during that interval.

SCHEDPHARM90-dcet1

## Definitions

**Dependent**

A child also includes a minor grandchild, niece or nephew for whom you provide food, clothing and shelter on a regular and continuous basis when the District of Columbia schools are in regular session, provided such child's legal guardian, if not you, is not covered by an accident or Sickness policy.

HC-DFS1866 01-23
ET

**Hospital Confinement or Confined in a Hospital**

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Use Disorder Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

HC-DFS815 11-15
ET

**Prescription Drug Product**

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

following categories if specifically identified on the Prescription Drug List:

- Certain durable products and supplies that support drug therapy;
- Certain diagnostic testing and screening services that support drug therapy;
- Certain medication consultation and other medication administration services that support drug therapy;
- Certain digital products, applications, electronic devices, software and cloud-based service solutions used to predict, detect and monitor health conditions in support of drug therapy;
- Medically Necessary and appropriate diabetic supplies.

HC-DFS1865 01-23

ET

**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

**Important Information**

**Rebates and Other Payments**

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

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

HC-IMP463 01-26

ET

# Eligibility - Effective Date

## Dependent Insurance

### Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

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

Your Dependents will be insured only if you are insured.

**Exception for Newborns**

If notice is given within 60 days of the birth of the child, the insurer may not deny coverage for a child due to the failure of the insured to timely notify the insurer of the birth of the child.

HC-ELG369 01-26
ET

## Covered Expenses

- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: a baseline mammogram for women ages 35 through 39; a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; a mammogram every year for women age 50 and over; and one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician's recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.
- charges made for diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint.
- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.
- charges for general anesthesia and hospitalization services for dental procedures for an individual who is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.
- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.
- charges made for medical, surgical and Hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy. Services provided to you by a certified nurse-midwife or a licensed midwife, in a home setting or in a licensed birthing center. Coverage for a mother and her newborn child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. Post delivery care for a mother and her newborn shall be covered. Post delivery care includes: a postpartum assessment and newborn assessment, which can be provided at the Hospital, the attending Physician's office, and outpatient maternity center or in the home by an Other Health Care Professional trained in mother and newborn care. The services may include physical assessment of the newborn and mother, and the performance of any clinical tests and immunizations in keeping with prevailing medical standards.
- charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: have vertebral abnormalities; are receiving long-term glucocorticoid (steroid) therapy; have primary hyperparathyroidism; have a family history of osteoporosis; and/or are estrogen-deficient individuals who are at clinical risk for osteoporosis.
- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be Medically Necessary by the Physician and in consultation with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.
- charges for newborn and infant hearing screening as well as any Medically Necessary reevaluations and follow-up care for hearing impairment and screenings for congenital cytomegalovirus through 12 months of age.

- charges for the coverage of child health supervision services from birth to age 16. Child health supervision services are physician-delivered or supervised services that include periodic visits which include a history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests.

HC-COV1666 01-26 ET

**Short-Term Rehabilitative Therapy and Spinal Manipulation Care Services**

Any references to “Chiropractic Care” are hereby changed to “Spinal Manipulation”.

HC-COV53 04-10 V1-ET

# Medical Conversion Privilege

**For You and Your Dependents**

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

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

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

**Employees Entitled to Convert**

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

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

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

**Dependents Entitled to Convert**

The following Dependents are also Entitled to Convert:

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

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

**Overinsured**

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

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

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

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

**Converted Policy**

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

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

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

HC-CNV28 04-14
V1-ET

# Exclusions, Expenses Not Covered and General Limitations

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

HC-EXC640 01-26
ET

# Termination of Insurance

## Dependents

**Special Continuation of Medical Insurance**

**For Dependents of Military Reservists**

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

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

**Reinstatement of Medical Insurance**

**Employees and Dependents**

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

Limitation to any new condition that you or your Dependent may have developed during the period that coverage was interrupted due to active military duty.

**Provisions Applicable to Reinstatement**

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

**Conversion Available Following Continuation**

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

HC-TRM234 01-26
ET

## Medical Benefits Extension Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury, Sickness or pregnancy, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury, Sickness or pregnancy.

However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date a succeeding carrier agrees to provide coverage without limitation for the disabling condition;
- the date you are no longer Totally Disabled;
- 12 months from the date the policy is canceled; or
- for maternity/pregnancy benefits, through 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-BEX69 01-26
ET

## Definitions

**Dependent – For Medical Insurance**

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

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

HC-DFS1978 01-25
V1-ET

**Spinal Manipulation Care**

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

HC-DFS1684 01-23
ET

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

**CERTIFICATE RIDER –** Georgia Residents

Rider Eligibility: Each Employee who is located in Georgia

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 Georgia group insurance plans covering insureds located in Georgia. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETGARDR

## Covered Expenses

- charges made for colorectal cancer screening, examinations and laboratory tests according to the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology, if deemed appropriate by the Physician in consultation with the insured.

HC-COV1675 01-26

ET2

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

**CERTIFICATE RIDER –** Illinois Residents

Rider Eligibility: Each Employee who is located in Illinois

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

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

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

HC-ETILRDR

# Important Information About Your Medical Plan

### Woman's Principal Health Care Provider Notice

Under this plan, you can see a Participating Provider OB/GYN or family practitioner for covered services without authorization from your Primary Care Physician. In order to comply with Illinois law, health plans must provide members with the following notice. Please note, this notice does not change either your benefits or the plan's open access to OB/GYNs.

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

Illinois law allows you to select "a woman's principal health care provider" in addition to your selection of a Primary Care Physician. "A woman's principal health care provider" is a Physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice. "A woman's principal health care provider" may be seen for care without referrals from your Primary Care

Physician. If you have not already selected "a woman's principal health care provider," you may do so now or at any other time. You are not required to have or to select "a woman's principal health care provider."

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

HC-IMP367 01-23 ET

# The Schedule

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

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

SCHEDIL-ETC

# The Schedule

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

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

SCHED IL ET-1

# The Schedule

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

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

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

SCHED IL ET-2

## Certification Requirements - Out-of-Network

**For You and Your Dependents**

**Pre-Admission Certification/Continued Stay Review for Hospital Confinement**

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

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

HC-PAC111 01-20 V1 ET

## Covered Expenses

- charges for colorectal cancer screening prescribed by a Physician, and a follow-up colonoscopy when a follow-up colonoscopy is determined by a health care provider to be Medically Necessary. Such follow-up colonoscopy is not subject to any member cost share.
- charges for anesthesia and associated facility charges for dental care provided in a Hospital or ambulatory surgical facility to a covered person who is age 6 or younger; or has a medical condition that requires hospitalization or general anesthesia for dental care, or is a person with a disability. Charges for anesthesia provided in a dentist or oral surgeon’s office for dental care provided to a covered person who is under age 26 and has been diagnosed with an

autism spectrum disorder or a developmental disability are also covered.

- charges made for or in connection with low-dose mammography screening including breast tomosynthesis for detecting the presence of breast cancer. Coverage shall include: a baseline mammogram for women ages 35 to 39; an annual mammogram for women age 40 and older; and mammograms at intervals considered Medically Necessary for women less than age 40 who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors. Coverage also includes a comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches as well as a screening MRI when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches. Low dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device and image receptor, with radiation exposure delivery of less than one rad per breast for two views of an average sized breast. This term also includes digital mammography and includes breast tomosynthesis. The term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.
- charges made for complete and thorough clinical breast exams performed by a Physician licensed to practice medicine in all its branches, an advanced practice nurse who has a collaborative agreement with a collaborating Physician that authorizes breast examinations, or a Physician assistant who has been delegated authority to provide breast examinations. Coverage shall include such an exam at least once every three years for women ages 20 to 40; and annually for women 40 years of age or older.
- charges for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including, but not limited to the use of intravenous immunoglobin therapy.
- charges for donated breast milk for a covered Dependent child age 12 months or younger, when prescribed by a licensed medical practitioner and all of the following conditions are met:
  - the milk is obtained from a human milk bank licensed by the Department of Public Health or that meets Human Milk Banking Association quality guidelines; and
  - the child's mother is medically or physically unable to produce, or unable to produce sufficient quantities of, maternal breast milk, or the maternal breast milk is contraindicated; and
  - the milk is Medically Necessary for the child; and
  - one or more of the following applies to the child: birth weight is below 1,500 grams; congenital or acquired condition that places the child at high risk for development of necrotizing enterocolitis; hypoglycemia; congenital heart disease; has had or will have an organ transplant; sepsis; or any other serious congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports treatment or recovery of the child.
- charges for long-term antibiotic therapy, including necessary office visits and ongoing test, for a person with a tick-borne disease when determined to be Medically Necessary and ordered by a Physician licensed to practice medicine in all its branches after making a thorough evaluation of the person's symptoms, diagnostic test results, or response to treatment. An experimental drug must be covered as a long-term antibiotic therapy if it is approved for an indication by the United States Food and Drug Administration. A drug, including an experimental drug, shall be covered for an off-label use in the treatment of a tick-borne disease if the drug has been approved by the United States Food and Drug Administration.
- charges for one annual office visit for a whole body skin examination for lesions suspicious for skin cancer.

**Virtual Physician Services**

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

Includes charges for the delivery of real-time mental health and Substance Use Disorder consultations and services, via secure telecommunications technologies that shall include video capability, telephone and internet, when such

consultations and services are delivered by a behavioral provider and are similar to office visit services provided in a face-to-face setting.

HC-COV1582 01-24
ET

**Mental Health and Substance Use Disorder Services**

The plan covers charges for mental health and substance use disorder services.

Coverage includes:

- charges for one annual mental health prevention and wellness visit for a covered person regardless of age, not subject to any member cost share, when the visit is with a Participating Provider.
- charges for treatment of mental health and substance use disorder conditions related to pregnancy or postpartum complications. Medical Necessity for the first 48 hours of covered mental health and/or substance use disorder services must be determined solely by the provider.
- charges for evidence-based early treatment of a serious mental illness in a covered person under age 26:
  - coordinated specialty care for first episode psychosis treatment based on the Recovery After an Initial Schizophrenia Episode (RAISE) treatment model, excluding education and employment support elements of the model.
  - assertive community treatment (ACT) and community support team (CST) treatment. ACT and CST both mean bundled services delivered through a multi-disciplinary team of Mental Health professionals.

Medically Necessary treatment that is otherwise eligible for coverage under this plan cannot be limited or excluded on the basis that the treatment should be or is covered by a public entitlement program, including but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance.

**Mental Health Disorders** are conditions which consider the following factors as defined in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM):

- a behavioral or psychological syndrome or pattern that occurs in an individual.
- reflects an underlying psychobiological dysfunction.
- the consequences of which are clinically significant distress (such as a painful symptom) or disability (such as impairment in one or more important areas of functioning).
- must not be merely an expected response to common stressors and losses (such as loss of a loved one) or a culturally sanctioned response to a particular event (such as trance states in religious rituals).
- primarily a result of social deviance or conflicts with society.

**Substance Use Disorders** involve patterns of symptoms caused by using a substance that an individual continues taking despite its negative effects, considering the following factors as defined in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM):

- using more of a substance than intended or using it for longer than a person is meant to use it.
- trying to cut down or stop using the substance, but unable to do so.
- experiencing intense cravings or urges to use the substance.
- needing more of the substance to get a desired effect, also referred to as tolerance.
- developing withdrawal symptoms when not using the substance.
- spending more time getting and using drugs and recovering from substance use.
- neglecting responsibilities at home, work, or school because of substance use.
- continuing to use the substance despite the substance causing problems to physical or mental health.
- giving up important or desirable social and recreational activities due to substance use.
- using substances in risky settings that put you or your Dependent in danger.

**Inpatient Mental Health Services (including Mental Health Acute Inpatient Services and Mental Health Residential Treatment Services)**

**Mental Health Acute Inpatient Services** are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Mental Health Disorder.

**Mental Health Residential Treatment Services** are services provided by a Hospital or Mental Health Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for the evaluation and treatment of a subacute Mental Health Disorder.

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

**Outpatient Mental Health Services (including Mental Health Partial Hospitalization and Mental Health Intensive Outpatient Services)**

**Outpatient Mental Health Services** are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Mental Health Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Mental Health Residential Treatment Center, for evaluation and treatment of a Mental Health Disorder.

**Mental Health Partial Hospitalization Services** are active, time-limited, ambulatory mental health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Mental Health Disorders, similar in intensity to that provided in an Inpatient Hospital or Mental Health Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

**Mental Health Intensive Outpatient Services** are active, time-limited, ambulatory mental health treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Mental Health Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

**Inpatient Substance Use Disorder Services (including Acute Inpatient Detoxification, Substance Use Disorder Inpatient Rehabilitation, Substance Use Disorder Residential Treatment Services)**

**Acute Inpatient Detoxification Services** are services provided by a Hospital or Substance Use Disorder Residential Treatment Center for around-the-clock, intensive management and monitoring of individuals requiring acute detoxification as the initial phase of evaluation and treatment for a Substance Use Disorder.

**Substance Use Disorder Inpatient Treatment Services** are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Substance Use Disorder.

**Substance Use Disorder Residential Treatment Services** are services provided by a Hospital or Substance Use Disorder Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for evaluation and treatment of a subacute Substance Use Disorder.

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

**Outpatient Substance Use Disorder Rehabilitation Services (including Outpatient Detoxification, Substance Use Disorder Partial Hospitalization, and Substance Use Disorder Intensive Outpatient Services)**

**Outpatient Substance Use Disorder Services** are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Substance Use Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Substance Use Disorder Residential Treatment Center, for evaluation and treatment of a Substance Use Disorder.

**Substance Use Disorder Partial Hospitalization Services** are active, time-limited, ambulatory substance use disorder treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Substance Use Disorders, similar in intensity to that provided in an Inpatient Hospital or Substance Use Disorder Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

**Substance Use Disorder Intensive Outpatient Services** are active, time-limited, ambulatory substance use disorder treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Substance Use

Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

**Substance Use Disorder Detoxification Services** are services provided for daily, active comprehensive management and monitoring of individuals requiring detoxification as part of evaluation and treatment of a Substance Use Disorder, but that do not require a person to be Confined in a Hospital or Substance Use Disorder Residential Treatment Center.

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs.

HC-COV1584 01-24
ET

**Durable Medical Equipment**

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

HC-COV1035 01-21
ET

# Prescription Drug Benefits

## Covered Expenses

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

**Prescription Drug List Exceptions**

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

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

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

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

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

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

medical condition under consideration while on a current or previous health insurance or health benefit plan.

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

HC-PHR700 01-23
ET

## Limitations

### Step Therapy

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

HC-PHR730 01-23
ET

## Exclusions, Expenses Not Covered and General Limitations

- care for health conditions that are required by state or local law to be treated in a public facility except as described in the Mental Health and Substance Use Disorder Covered Expense provision.
- care required by state or federal law to be supplied by a public school system or school district except as described in the Mental Health and Substance Use Disorder Covered Expense provision.
- for any charges related to care provided through a public program, other than Medicaid, except as described in the Mental Health and Substance Use Disorder Covered Expense provision.

HC-EXC609 01-24
ET

## Definitions

### Dependent

Dependents are:

- your civil union partner as described in Illinois law.

HC-DFS1999 01-24
ET

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

**CERTIFICATE RIDER –** Indiana Residents

Rider Eligibility: Each Employee who is located in Indiana

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 Indiana group insurance plans covering insureds located in Indiana. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETINRDR

## Important Notices

### Indiana Notice

### Cigna Health and Life Insurance Company Claim Offices Servicing Indiana

We are here to serve you.

As our certificate holder, your satisfaction is very important to us. If you have a question about your certificate, if you need assistance with a problem, or if you have a claim, you should first contact your Benefits Administrator or us at the numbers

and addresses listed below. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion.

**Medical Questions**

Cigna Health and Life Insurance Company
Midwest Claim Service Center
P.O. Box 2100
Bourbonnais, IL 60914 Tel. 1-800-Cigna24

Should you feel you are not being treated fairly with respect to a claim, you may contact the Indiana Department of Insurance with your complaint.

To contact the Department, write or call:

Consumer Services Division
Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, IN 46204 – 2787
1-800-622-4461 or 1-317-232-2395

HC-IMP41 04-10
V1-ET

## Covered Expenses

- charges for reimbursement payments made to the Indiana First Steps program for Early Intervention Services incurred by a Dependent child enrolled in the program, from birth through age two. Payments made directly by the program will be credited toward Deductibles or Copayments.
- coverage for or in connection with expenses arising from medical and dental care (including orthodontic and oral surgery treatment) involved with the management of cleft lip and cleft palate.
- charges made for mammograms including, but not limited to:
  - a single baseline mammogram for women ages 35 through 39;
  - an annual mammogram for women under age 40 who are considered to be at risk;
  - an annual mammogram for women age 40 and over;
  - additional mammography views when necessary for proper evaluation; and
  - ultrasound services when considered by the treating Physician to be medically necessary.

HC-COV1604 01-25
ET2

# Prescription Drug Benefits

## Limitations

### Prescription Eye Drops

Refill of prescription eye drops will be allowed when:

- for a 30 day supply, a request for a refill not earlier than 25 days after the date the prescription eye drops were last dispensed.
- for a 90 day supply, a request for a refill not earlier than 75 days after the date the prescription eye drops were last dispensed.
- the prescribing practitioner has indicated on the prescription that the prescription eye drops are refillable and the refill requested does not exceed the refillable amount remaining on the prescription.

HC-PHR470 01-21
ET

# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance, self-esteem. It does not include the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn Dependent child.
- surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ). However, Medically Necessary treatment of TMJ disorder and expenses arising from dental care (including orthodontic and oral surgery treatment) involved with the management of cleft lip and cleft palate for a newborn Dependent child are covered.

HC-EXC616 01-25
ET

**When You Have A Complaint Or An Appeal**

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

We want you to be completely satisfied with the care and services you receive. That is why we have established a process for addressing your concerns and solving your problems.

**Step Therapy Appeal**

A procedure for requesting a protocol exception will be published on our web site and provided to You in writing. The procedure must include the following provisions:

- A description of the manner in which You may request a protocol exception.
- That we will make a determination concerning a protocol exception request, or an appeal of a denial of a protocol exception request, not more than in an urgent care situation, of (1) business day after receiving the request or appeal; or in a non-urgent care situation, three (3) business days after receiving the request or appeal.
- That a protocol exception will be granted if any of the following apply:
  - a preceding prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to You.
  - a preceding prescription drug is expected to be ineffective, based on both of the following:
    - the known clinical characteristics of the insured.
    - known characteristics of the preceding prescription drug, as found in sound clinical evidence.
  - we have previously received:
    - a preceding prescription drug; or
    - another prescription drug that is in the same pharmacologic class or has the same mechanism of action as a preceding prescription drug; and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
  - based on clinical appropriateness, a preceding prescription drug is not in the best interest of Yours because the use of the preceding prescription drug is expected to:
    - cause a significant barrier to Your adherence to or compliance with Your plan of care;
    - worsen a comorbid condition of Yours; or
    - decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.
- That when a protocol exception is granted, we will notify You and the Your health care provider of the authorization for coverage of the prescription drug that is the subject of the protocol exception.
- If a protocol exception request or an appeal of a denied protocol exception request; results in a denial of the protocol exception, we will provide You and Your health care provider notice of the denial, including a detailed, written explanation of the reason for the denial and the clinical rationale that supports the denial.
- We may request a copy of relevant documentation from Your medical record in support of a protocol exception.

HC-APL502 01-25
ET

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

**CERTIFICATE RIDER –** Kentucky Residents

Rider Eligibility: Each Employee who is located in Kentucky

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 Kentucky group insurance plans covering insureds located in Kentucky. These provisions supersede any

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

HC-ETKYRDR

# Important Information

### Rebates and Other Payments

Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals covered under your plan and Prescription Drug Products included on the Prescription Drug List. These rebates or remuneration are not obtained on you or your Employer's or plan's behalf or for your benefit. Cigna, its affiliates and the plan are not obligated to pass these rebates on to you. Cigna and its affiliates or designees may also conduct business with various pharmaceutical manufacturers separate and apart from this plan's Medical Pharmaceutical and Prescription Drug Product benefits. Such business may include, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this plan. Cigna and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.

### Coupons, Incentives and Other Communications

At various times, Cigna or its designee may send mailings to you or your Dependents or to your Physician that communicate a variety of messages, including information about Medical Pharmaceuticals and Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you or your Dependents, at your discretion, to purchase the described Medical Pharmaceutical and Prescription Drug Product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Cigna, its affiliates and the plan are not responsible in any way for any decision you make in connection with any coupon, incentive, or other offer you may receive from a pharmaceutical manufacturer or Physician.

If the following text "If Cigna determines….required to pay." is included in your certificate, it does not apply to you.

If Cigna determines that a Pharmacy, pharmaceutical manufacturer or other third party is or has waived, reduced, or forgiven any portion of the charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Prescription Drug Product without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of plan benefits in connection with the Prescription Drug Product, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the Pharmacy, pharmaceutical manufacturer or other third party represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by the plan.

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

# Eligibility - Effective Date

### Special Enrollment for Pregnant Employees

A pregnant Employee and her Dependents may enroll at any time after the commencement of the pregnancy. Coverage will be effective as of the first of the month in which you elect the insurance coverage.

# The Schedule

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

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

SCHEDKY ET1

## The Schedule

The following "Note for Genetic Testing for Cancer Risk" is hereby added to your medical schedule:

Note for Genetic Testing for Cancer Risk: Services from an out-of-network provider will be covered at the usual out-of-network cost share unless an in-network provider is not available for services, then services will be covered at the standard in-network cost share elected by the plan.

SCHEDKY ET2

## The Schedule

Any existing provision regarding "Diabetic Equipment" in the medical schedule of your certificate is hereby removed.

SCHEDKY ET3

## The Schedule

The provisions "Outpatient Therapy Services" and "Chiropractic Care" (if included separately) found in the medical schedule are amended to indicate they will be subject to the same cost shares as any other Primary Care Physician's Office Visit.

SCHEDKY ET

## The Schedule

For charges made for Medically Necessary treatment of Mental Health and Substance Abuse Services, including any related prescription drug charges, Covered Expenses will be payable the same as for other illnesses, including any deductibles, Lifetime or annual maximums, day or visit or dollar limits, episodes of care limits, copayments, coinsurance levels, accumulation to any out-of-pocket amount, any increase to 100% once the out-of-pocket amount has been reached, and any other cost-sharing arrangements. Any Mental Health or Substance Abuse deductibles, maximums, limits, copayments, coinsurance levels, out-of-pocket provisions, and cost-sharing arrangements shown in The Schedule that are not the same as for other illnesses will not apply.

SCHEDKY ET4

### Covered Expenses

- charges for cochlear implants for persons diagnosed with profound hearing impairment.
- charges for Medically Necessary treatment of temporomandibular joint and craniomandibular jaw disorders.
- charges for or in connection with hospitalization, ambulatory surgical facility charges and general anesthesia for dental procedures provided the person being treated is under nine years of age; or has serious mental, physical or behavioral problems and the Dentist or admitting Physician certifies that hospitalization or anesthesia is required to safely perform the procedures effectively.
- charges made for mammograms, diagnostic breast exams and supplemental breast exams.

  Coverage for surgical services for a mastectomy must also include coverage for low-dose mammography screenings for individuals who have no sign or symptom of breast cancer upon self-referral or referral by a Physician. This includes:

  - one mammogram for individuals ages 35 through 39;
  - one mammogram every two years for individuals ages 40 through 49; and
  - one mammogram per year for individuals ages 50 and over.

  "Examination of the breast" includes a mammogram and an examination using breast magnetic resonance imaging or breast ultrasound.

  "Mammogram" means an x-ray exam of the breast with at least two (2) views of each breast and with an average radiation exposure at the current recommended level as set forth in guidelines of the American College of Radiology, using equipment dedicated specifically for mammography, including:

  - the x-ray tube, filter, compression device, screens, film, and cassettes;
  - digital mammography; and
  - breast tomosynthesis.

  "Diagnostic breast exam" means a Medically Necessary and appropriate exam of the breast that is used to evaluate an abnormality seen or suspected from or detected by a screening exam for breast cancer or another means of examination.

"Supplemental breast screening exam" means a Medically Necessary and appropriate exam of the breast that is:

- used to screen for breast cancer when there is no abnormality seen or suspected; and
- based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

- charges for Medically Necessary equipment, outpatient self-management training and education including medical nutrition therapy, for individuals with insulin-dependent, insulin-using, gestational, and noninsulin-using diabetes.
- charges for tobacco cessation services recommended by the U.S. Preventive Services Task Force, including individual, group, and telephone counseling, and any combination thereof.
- charges for hearing aids and all related services for individuals under 18 years of age when prescribed by licensed audiologists and dispensed by an audiologist or hearing instrument specialist. Coverage includes one hearing aid per hearing impaired ear every 36 months; and related services necessary to assess, select and appropriately adjust or fit the hearing aid to ensure optimal performance. A hearing aid is any wearable, non-disposable instrument or device designed to aid or compensate for impaired hearing and any parts, attachments or accessories, including ear molds, but excluding batteries and cords.
- charges for colorectal cancer examinations and laboratory tests that are administered at a frequency identified in the most recent version of the American Cancer Society guidelines. Includes screening, labs and removal of polyps related to a preventive Colonoscopy. The covered individual shall be 45 years of age or older or less than 45 years of age and at high risk for colorectal cancer.
- charges for biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of an individual's disease or condition to guide treatment decisions when supported by medical and scientific evidence.
- charges made for the diagnosis and treatment of autism spectrum disorders.
- charges for maternity coverage including for Dependents, regardless of age. Coverage includes maternity care associated with pregnancy, childbirth and postpartum care; labor and delivery; breastfeeding services and supplies required under Federal law; and inpatient care for the mother and newborn child for at least 48 hours of inpatient care after a vaginal delivery and at least 96 hours of care after a cesarean section. Any decision to shorten the stay must be made by the Physician in consultation with the mother. If the mother and newborn are discharged earlier than the 48/96 hours, at least one home health care visit will be covered, which includes the collection of an adequate sample for hereditary and metabolic newborn screening. Additional home health care visits may be covered if Medically Necessary. If the mother and newborn receive the full 48/96 hours of inpatient hospital stay after delivery, home health care visits are not required to be covered. Coverage also includes in-home programs for pregnant and postpartum women; and telehealth services related to care associated with pregnancy, childbirth and postpartum care. 'In-home program' means a program for the treatment of substance use disorder which is accessed through telehealth or digital health services.

**Genetic Testing for Cancer Risk**

Charges for any genetic test for cancer risk that is recommended by a physician, physician assistant, genetic counselor or an advanced practice registered nurse if the recommendation is consistent with the most recent version of genetic testing guidelines published by the National Comprehensive Cancer Network (NCCN).

"Genetic test for cancer risk" means a blood, saliva, or tissue typing test that reliably determines the presence or absence of an inherited genetic characteristic that is generally accepted in the medical or scientific community as being associated with a statistically significant increased risk of cancer development.

**Telehealth**

**Dedicated Telehealth Providers**

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

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

**Telehealth Physician Services**

A mode of delivering healthcare services through the use of telecommunication technologies, including synchronous and asynchronous technology, remote patient monitoring technology, and audio-only encounters, by a health care

provider to a patient or to another health care provider at a different location.

Telehealth shall not include:

- The delivery of health care services through electronic mail, text, chat, or facsimile unless a state agency authorized or required to promulgate administrative regulations relating to telehealth determines that health care services can be delivered via these modalities in ways that enhance recipient health and well-being and meet all clinical and technology guidelines for recipient safety and appropriate delivery of services; or
- Basic communication between a health care provider and a patient, including appointment scheduling, appointment reminders, voicemails, or any other similar communication intended to facilitate the actual provision of healthcare services either in-person or via telehealth.

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

**Enteral Nutrition**

Enteral Nutrition means medical foods or supplements 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).

Coverage also includes:

- charges for the necessary care and treatment of medically diagnosed inherited metabolic diseases for a newborn child;
- charges for therapeutic food, formulas, supplements, and low protein modified food products for the therapeutic treatment of inherited metabolic diseases, including mitochondrial disease, if prescribed and administered under the direction of a Physician; and
- charges for a one hundred percent (100%) human diet, if the one hundred percent (100%) human diet and supplemented milk fortifier products are prescribed for the prevention of Necrotizing Enterocolitis and associated comorbidities and are administered under the direction of a Physician.

Medical disorders requiring specialized nutrients or formulas means the following inherited metabolic disorders: Phenylketonuria; Hyperphenylalaninemia; Tyrosinemia (types I, II, and III); Maple syrup urine disease; a-ketoacid dehydrogenase deficiency; Isovaleryl-CoA dehydrogenase deficiency; 3-methylcrotonyl-CoA carboxylase deficiency; 3-methylglutaconyl-CoA hydratase deficiency; 3-hydroxy-3-methylglutaryl-CoA lyase deficiency (HMG-CoA lyase deficiency); B-ketothiolase deficiency; Homocystinuria; Glutaric aciduria (types I and II); Lysinuric protein intolerance; Non-ketotic hyperglycinemia; Propionic acidemia; Gyrate atrophy; Hyperornithinemia/hyperammonemia/homocitrullinuria syndrome; Carbamoyl phosphate synthetase deficiency; Ornithine carbamoyl transferase deficiency; Citrullinemia; Argininosuccinic aciduria; Methylmalonic acidemia; and Arginine Mia.

"Milk fortifier" means a commercially prepared human milk fortifier made from concentrated one hundred percent (100%) human milk.

"One hundred percent (100%) human diet" means the supplementation of a mother's expressed breast milk or donor milk with a milk fortifier.

"Therapeutic food, formulas, and supplements" means products intended for the dietary treatment of inborn errors of metabolism or genetic conditions, including but not limited to mitochondrial disease, under the direction of a physician, and includes the use of vitamin and nutritional supplements such as coenzyme Q10, vitamin E, vitamin C, vitamin B1, vitamin B2, vitamin K1, and L-carnitine.

"Low protein modified food" means a product formulated to have less than one (1) gram of protein per serving and intended for the dietary treatment of inborn errors of metabolism or genetic conditions under the direction of a physician.

## Medical Conversion Privilege

**For You and Your Dependents**

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

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

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

**Employees Entitled to Convert**

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

- you are not eligible for other individual insurance coverage on a guaranteed issue basis.
- you are not eligible for similar benefits under another group plan (insured or uninsured).
- 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 coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

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

**Dependents Entitled to Convert**

The following Dependents are also Entitled to Convert:

- a child who is not eligible for other individual insurance coverage on a guaranteed issue basis, not eligible for similar benefits under another group plan (insured or uninsured), 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, not eligible for similar benefits under another group plan (insured or uninsured), 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, not eligible for similar benefits under another group plan (insured or uninsured), is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

**Overinsured**

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

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

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

**Converted Policy**

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

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

The Converted Policy may 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.

## The Schedule

**Oral Chemotherapy Medication**

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

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

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

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# Prescription Drug Benefits

## Limitations

**Prior Authorization**

Prior authorization will not be required for a prescription drug that is used in the treatment of alcohol or opioid use disorder and contains Methadone, Buprenorphine or Naltrexone; or that was approved by the United States Food and Drug Administration for the mitigation of opioid withdrawal symptoms.

**Prescription Eye Drops**

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

**Supply Limit Exceptions**

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

## Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule, as well as any limitations or exclusions set forth in this plan. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

**Deductible**

Your plan requires that you pay the costs for covered Prescription Drug Products up to the Deductible amount set forth in The Schedule. Until you meet that Deductible amount, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy will be the lowest of the following amounts:

- the Prescription Drug Charge; or
- the Network Pharmacy’s submitted Usual and Customary (U&C) Charge, if any.

The Schedule sets forth your costs for covered Prescription Drug Products after you have satisfied the Deductible amount.

**Copayment**

Your plan requires that you pay a Copayment for covered Prescription Drug Products as set forth in The Schedule. After satisfying any applicable annual Deductible set forth in The Schedule, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy and that is subject to a Copayment requirement will be the lowest of the following amounts:

- the Copayment for the Prescription Drug Product set forth in The Schedule; or
- the Prescription Drug Charge; or
- the Network Pharmacy’s submitted Usual and Customary (U&C) Charge, if any.

**Payments at Non-Network Pharmacies**

Any reimbursement due to you under this plan for a covered Prescription Drug Product dispensed by a non-Network Pharmacy may be determined by applying the Deductible, if any, and/or non-Network Pharmacy Coinsurance amount set forth in The Schedule to the average wholesale price (or "AWP"), or other benchmark price Cigna applies, for a Prescription Drug Product dispensed by a non-Network Pharmacy. Your reimbursement, if any, for a covered Prescription Drug Product dispensed by a non-Network Pharmacy will never exceed the average wholesale price (or other benchmark price applied by Cigna) for the Prescription Drug Product.

**Payments**

Any reimbursement due to you under this plan for a covered Prescription Drug Product dispensed by a Pharmacy may be determined by applying the Deductible, if any, and/or Pharmacy Coinsurance amount set forth in The Schedule to the average wholesale price (or "AWP"), or other benchmark price Cigna applies, for a Prescription Drug Product dispensed by a Pharmacy. Your reimbursement, if any, for a covered Prescription Drug Product dispensed by a Pharmacy will never exceed the average wholesale price (or other benchmark price applied by Cigna) for the Prescription Drug Product.

When a treatment regimen contains more than one type of Prescription Drug Products that are packaged together for your or your Dependent's convenience, any applicable Copayment or Coinsurance may apply to each Prescription Drug Product.

You will need to obtain prior approval from Cigna or its Review Organization for any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded. If Cigna or its Review Organization approves coverage for the Prescription Drug Product because it meets the applicable coverage exception criteria, the Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

The amount you or your Dependent pays for any excluded Prescription Drug Product or other product or service will not be included in calculating any applicable plan Out-of-Pocket Maximum. You are responsible for paying 100% of the cost (the amount the Pharmacy charges you) for any excluded Prescription Drug Product or other product.

### Exclusions

- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications, such as smoking cessation medications, or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- 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, or unless covered under the Enteral Nutrition benefit in the Covered Expenses section.

## Exclusions, Expenses Not Covered and General Limitations

### Exclusions and Expenses Not Covered

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

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

- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include: bandages and other disposable medical supplies, skin preparations, except as specified in the "Home Health Care Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- membership costs and fees associated with health clubs, weight loss programs or smoking cessation programs not recommended by the U.S. Preventive Services Task Force.
- all nutritional supplements, formulae, enteral feedings, supplies and specialty formulated medical foods, whether prescribed or not, except for infant formula needed for the treatment of inborn errors of metabolism; except for 100% human milk fortifiers for the prevention of Necrotizing Enterocolitis.

# Termination of Insurance

**Special Continuation of Medical Insurance**

**For Employees and Dependents**

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

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

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

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

# Definitions

**Prescription Drug Product**

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

- Certain durable products and supplies that support drug therapy;
- Certain diagnostic testing and screening services that support drug therapy;
- Certain medication consultation and other medication administration services that support drug therapy;
- Certain digital products, applications, electronic devices, software and cloud-based service solutions used to predict, detect and monitor health conditions in support of drug therapy;
- Medically Necessary and appropriate diabetic supplies.

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

**CERTIFICATE RIDER –** Maryland Residents

Rider Eligibility: Each Employee who is located in Maryland

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

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

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

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# Important Notices

**Qualified Medical Child Support Order (QMCSO)**

**Eligibility for Coverage Under a QMCSO**

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

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

business days of our receipt of the QMCSO from your Employer.

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

**Qualified Medical Child Support Order Defined**

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

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

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

**Claims**

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

**Payment of Benefits**

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

**Termination of Coverage Under a QMCSO**

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

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# The Schedule

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

**Note:** OB/GYN provider is considered a Specialist.

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

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

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

The Medical Schedule is amended to indicate the following:

**PSA, PAP Smear and Mandated Screening Tests**

Screenings Include:

- Osteoporosis prevention and treatment including bone mass measurement

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

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

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

**Outpatient Facility Services**

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

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

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

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

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

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

**Additional Benefits and Provisions**

Calendar or Contract Year Maximum: Unlimited

Includes:

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

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

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

**Inpatient**

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

**Residential Crisis Services**

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

**Physician's Office Visit**

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

**Partial Hospitalization and Outpatient Facility**

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

SCHEDMD-ET1

## The Schedule

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

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

SCHED MD ET-24

## The Schedule

The provision "Obesity/Bariatric Surgery" is hereby added to your medical schedule. Obesity/Bariatric Surgery coverage will not be subject to any separate lifetime maximum and will be subject to the same deductibles, copayments and coinsurance as for other surgical procedures.

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### Covered Expenses

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

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

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

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

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

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

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

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

Examples of routine patient care costs and services include:

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

HC-COV1154 01-21

ET

# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

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

- the national institutes of health (NIH);
- an NIH cooperative group or an NIH center;
- the FDA in the form of an investigational new drug application;
- the federal department of veterans affairs; or
- an institutional review board of an institution in the state that has a multiple project assurance contract approved by the office of protection from research risks of the NIH.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition not noted herein.

  However, charges made for a continuous course of dental treatment for an accidental Injury to teeth are covered. Also,

facility charges and charges for general anesthesia or deep sedation which cannot be administered in a dental office are covered when Medically Necessary. Additionally, charges made by a Physician for any of the following surgical procedures are covered: excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a dentist other than the one who extracted the tooth). Charges for inpatient and outpatient services for orthodontics, oral surgery, and otologic, audiological, and speech/language treatment, involved with the management of the birth defect known as cleft lip or cleft palate, or both, are covered. Charges for diagnostic or surgical procedures involving a bone or joint of the face, neck or head if, under the accepted standards of the profession of the health care provider rendering the service, the procedure is Medically Necessary to treat a condition caused by congenital deformity, disease or Injury, are covered.

- medical and Hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under this plan. However, this exclusion does not apply to charges for inpatient hospitalization services and home visits, with respect to a newborn child, as provided for in the "Covered Expenses" section.

HC-EXC504 12-23 ET1

# Payment of Benefits

### Recovery of Overpayment

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

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

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

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

HC-POB148 01-19 ET

# Termination of Insurance

## Employees

### Injury or Sickness

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

HC-TRM197 12-23 ET

## Medical Benefits Extension Upon Coverage Termination

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

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

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

**Totally Disabled**

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

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

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

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

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

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

**Benefits Extension in Connection with Dental Care Services**

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

- begins before the date coverage terminates; and
- requires two or more visits on separate days to a dentist’s office.

HC-BEX4 04-10

V1-ET

## Definitions

**Sickness – For Medical Insurance**

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

HC-DFS107 04-10

V1-ET

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

**CERTIFICATE RIDER –** Massachusetts Residents

Rider Eligibility: Each Employee who is located in Massachusetts

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

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

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

HC-ETMARDR

# Eligibility - Effective Date

## Dependent Insurance

### Exception for Newborns

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

HC-ELG12 04-10

V1-ET

# Important Notices

### Mental Health Parity

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

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

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

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

- All other mental disorders not otherwise previously provided for, which are described in the most recent edition of the DSM.

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

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

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

**Your Rights Under Mental Health Parity**

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

***Complaints Concerning Non-Compliance With Mental Health Parity***

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

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

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

HC-NOT111 01-19

ET

## The Schedule

**The Schedule** of your medical certificate is amended to include the following provision in the "Preventive Care" section:

Mental Health Wellness Examinations

Limited to 1 examination per Calendar Year

**Note:**
Covered when performed by a licensed Mental Health Provider or primary care provider. This may be covered as part of the one annual preventive care visit.

Benefits will be covered at 100%/No charge In-Network.

If your plan includes Out-of-Network coverage, benefits will be subject to the Out-of-Network coinsurance and plan deductible (if applicable).

SCHEDMA-ET7

## The Schedule

The provision “Outpatient Therapy Services” in **The Schedule** of your medical certificate is hereby updated to indicate any maximum that applies to Outpatient Therapy Services does not apply to Speech and Hearing Services.

SCHEDMA-ET3

## The Schedule

If the Outpatient Therapy Services provision in **The Schedule** of your medical certificate includes Cardiac Rehab, it is hereby amended to remove and replace it with a separate benefit labeled “Outpatient Cardiac Rehabilitation.” The separate benefit is not subject to any benefit maximums and will be covered at the Primary Care Physician’s Office Visit or Specialty Care Physician’s Office Visit cost share level* (*note: if your plan is subject to tiering, the Outpatient Cardiac Rehabilitation Specialty Care Physician’s Office Visit cost share level will be covered at the non-Tier 1 Specialist level).

If “Outpatient Cardiac Rehabilitation” is covered as a separate benefit in **The Schedule** of your medical certificate, then it is hereby amended so that it is not subject to any benefit maximums and will be covered at the Primary Care Physician’s Office Visit or Specialty Care Physician’s Office Visit cost share level* (*note: if your plan is subject to tiering, the Outpatient Cardiac Rehabilitation Specialty Care Physician’s Office Visit cost share level will be covered at the non-Tier 1 Specialist level).

SCHEDMA-ET6

## The Schedule

The introductory section under the provision “Infertility Services” shown in your medical schedule is hereby replaced with the following:

**Fertility Services**

Coverage is provided for the following services:

- diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed.
- intrauterine insemination/artificial insemination services related to enabling conception regardless of an infertility diagnosis.
- access to reproductive services for the purposes of short term fertility preservation when an infertility condition is imminent.

SCHEDMA-ET8

## The Schedule

The provision “External Prosthetic Appliances” in **The Schedule** of your medical certificate is hereby updated as follows:

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

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

If you are not enrolled in a Network, Network Point of Service, Exclusive Provider Organization, or Open Access Plus In-Network medical plan, any maximum that applies to External Prosthetic Appliances Services shown in The Schedule does not apply to External Prosthetic Appliances meant to replace an arm or leg, in whole or in part.

SCHEDMA-ET4

## The Schedule

The provision “Substance Use Disorder” in **The Schedule** of your medical certificate is hereby updated as follows:

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

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

SCHEDMA-ET5

## 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.

- charges made for or in connection with the treatment of metastatic breast cancer by bone marrow transplants provided the treatment follows the guidelines reviewed and approved by the National Cancer Institute.
- charges for a scalp hair prosthesis worn for hair loss due to the treatment of any form of cancer or leukemia, provided that a Physician verifies in writing that the scalp hair prosthesis is Medically Necessary.
- charges for a newborn hearing screening test performed before the newborn is discharged from the Hospital or birthing center.
- charges for one hearing aid per hearing impaired ear for any covered person up to age 22 as Medically Necessary. Coverage includes all related services prescribed by a licensed audiologist or hearing instrument specialist, including the initial hearing aid evaluation, fitting and adjustments, including ear molds; these related services are not subject to the hearing aid maximum stated above.
- charges for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome including, but not limited to, the use of intravenous immunoglobulin therapy.
- charges made for screening for lead poisoning of a Dependent child from birth until 6 years of age.
- charges for Medically Necessary diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists, if such services are rendered within the lawful scope of practice for such practitioners, regardless of whether the services are provided in a Hospital, clinic or private office, and if such coverage does not extend to the diagnosis or treatment of speech, hearing and language disorders in a school-based setting.
- charges for treatment of an Injury or Sickness of an eligible newborn or adopted child, including the necessary care and treatment of medically-diagnosed congenital defects and birth abnormalities or premature birth.
- charges for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section for a mother and her newborn child. Any decision to shorten such minimum coverage will be made in accordance with rules and regulations promulgated by the Massachusetts Department of Public Health relative to early discharge (less than 48 hours for a vaginal delivery and 96 hours for a

caesarean delivery) and post-delivery care, including but not limited to: home visits; parent education; assistance and training in breast or bottle feeding; and the performance of any necessary and appropriate clinical tests. The first home visit may be conducted by a registered nurse, Physician or certified nurse-midwife. Any subsequent home visit determined to be clinically necessary must be provided by a licensed health care provider.

- charges for the diagnosis and treatment of autism spectrum disorder. Autism spectrum disorders are any of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. These disorders include: autistic disorder; Asperger’s disorder; and pervasive developmental disorders not otherwise specified.

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

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

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

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

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

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

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

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

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

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

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

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

  No coverage is provided for services to an individual under: an individualized family service plan; an individualized education program; an individualized service plan; or for services related to autism spectrum disorder provided by school personnel under an individualized education program.

- charges made for hormone replacement therapy services for peri- and postmenopausal women and for outpatient contraceptive drugs or devices which have been approved by the Food and Drug Administration (FDA), under the same terms and conditions as for other outpatient prescription drugs and devices.
- charges made for cardiac rehabilitation, according to standards developed by the Massachusetts Department of Public Health. Cardiac rehabilitation means a multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease, provided in either

a Hospital or other setting and meeting standards set forth by the Massachusetts Commissioner of Public Health.

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

**Enteral Nutrition**

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

Coverage includes:

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

HC-COV1572 01-25 ET

**Mental Health and Substance Use Disorder Services**

The plan covers charges for mental health and substance use disorder services.

**Mental Health Disorders** are conditions which consider the following factors as defined in the current version of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM):

- a behavioral or psychological syndrome or pattern that occurs in an individual.
- reflects an underlying psychobiological dysfunction.
- the consequences of which are clinically significant distress (such as a painful symptom) or disability (such as impairment in one or more important areas of functioning).
- must not be merely an expected response to common stressors and losses (such as loss of a loved one) or a culturally sanctioned response to a particular event (such as trance states in religious rituals).
- primarily a result of social deviance or conflicts with society.

**Substance Use Disorders** involve patterns of symptoms caused by using a substance that an individual continues taking despite its negative effects, considering the following factors as defined in the current version of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM):

- using more of a substance than intended or using it for longer than a person is meant to use it.
- trying to cut down or stop using the substance, but unable to do so.
- experiencing intense cravings or urges to use the substance.
- needing more of the substance to get a desired effect, also referred to as tolerance.
- developing withdrawal symptoms when not using the substance.
- spending more time getting and using drugs and recovering from substance use.

- neglecting responsibilities at home, work, or school because of substance use.
- continuing to use the substance despite the substance causing problems to physical or mental health.
- giving up important or desirable social and recreational activities due to substance use.
- using substances in risky settings that put you or your Dependent in danger.

**Inpatient Mental Health Services (including Mental Health Acute Inpatient Services and Mental Health Residential Treatment Services)**

**Mental Health Acute Inpatient Services** are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Mental Health Disorder.

**Mental Health Residential Treatment Services** are services provided by a Hospital or Mental Health Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for the evaluation and treatment of a subacute Mental Health Disorder.

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

**Outpatient Mental Health Services (including Mental Health Partial Hospitalization and Mental Health Intensive Outpatient Services)**

**Outpatient Mental Health Services** are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Mental Health Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Mental Health Residential Treatment Center, for evaluation and treatment of a Mental Health Disorder.

**Mental Health Partial Hospitalization Services** are active, time-limited, ambulatory mental health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Mental Health Disorders, similar in intensity to that provided in an Inpatient Hospital or Mental Health Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

**Mental Health Intensive Outpatient Services** are active, time-limited, ambulatory mental health treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Mental Health Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

**Inpatient Substance Use Disorder Services (including Acute Inpatient Detoxification, Substance Use Disorder Inpatient Rehabilitation, Substance Use Disorder Residential Treatment Services)**

**Acute Inpatient Detoxification Services** are services provided by a Hospital or Substance Use Disorder Residential Treatment Center for around-the-clock, intensive management and monitoring of individuals requiring acute detoxification as the initial phase of evaluation and treatment for a Substance Use Disorder.

**Substance Use Disorder Inpatient Treatment Services** are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Substance Use Disorder.

**Substance Use Disorder Residential Treatment Services** are services provided by a Hospital or Substance Use Disorder Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for evaluation and treatment of a subacute Substance Use Disorder.

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

**Intermediate Services**

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

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

**Outpatient Substance Use Disorder Rehabilitation Services (including Outpatient Detoxification, Substance Use Disorder Partial Hospitalization, and Substance Use Disorder Intensive Outpatient Services)**

**Outpatient Substance Use Disorder Services** are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Substance Use Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Substance Use Disorder Residential Treatment Center, for evaluation and treatment of a Substance Use Disorder.

**Substance Use Disorder Partial Hospitalization Services** are active, time-limited, ambulatory substance use disorder treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Substance Use Disorders, similar in intensity to that provided in an Inpatient Hospital or Substance Use Disorder Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

**Substance Use Disorder Intensive Outpatient Services** are active, time-limited, ambulatory substance use disorder treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Substance Use Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

**Substance Use Disorder Detoxification Services** are services provided for daily, active comprehensive management and monitoring of individuals requiring detoxification as part of evaluation and treatment of a Substance Use Disorder, but that do not require a person to be Confined in a Hospital or Substance Use Disorder Residential Treatment Center.

**Mental Health and Substance Use Disorder Services for children and adolescents**

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

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

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

**Intermediate Services**

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

- Community-based acute treatment (CBAT) are mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to ensure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to: daily medication monitoring; psychiatric assessment; nursing availability; 1:1 nursing care (as needed); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from inpatient services.

- Intensive community-based acute treatment (ICBAT) provides the same services as CBAT for children and adolescents but of higher intensity, including more frequent psychiatric and psychopharmacological evaluation and treatment and more intensive staffing and service delivery. ICBAT programs have the capability to admit children and adolescents with more acute symptoms than those admitted to CBAT. ICBAT programs are able to treat children and adolescents with clinical presentations similar to those referred to inpatient mental health services but who are able to be cared for safely in an unlocked setting. Children and adolescents may be admitted to an ICBAT directly from the community as an alternative to inpatient hospitalization; ICBAT is not used as a step-down placement following discharge from a locked, 24-hour setting.

HC-COV1580 01-25 ET

**External Prosthetic Appliances and Devices**

**Scalp Hair Prostheses**

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

HC-COV1074 01-21 ET

**Fertility Services**

- charges made for services related to:
  - diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed;
  - intrauterine insemination and artificial insemination related to enabling conception regardless of an infertility diagnosis;
  - access to reproductive services for the purposes of short term fertility preservation when an infertility condition is imminent.

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

Oral, vaginal and self-injectable fertility drugs are covered under the Pharmacy benefit.

Infertility is defined as:

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

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

The following are specifically excluded infertility services:

- donor charges and services except as noted above.
- pre-implantation genetic material and pre-implantation genetic screening (PGS/PGT-A) of parents/donors beyond what is covered by the medical plan.

HC-COV1573 01-25 ET

**Medical Pharmaceuticals**

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

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

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive

coverage, the covered person may be required to try a specific Medical Pharmaceutical before trying others. Medical Pharmaceuticals administered in an Inpatient facility are reviewed per Inpatient review guidelines.

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

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

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

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

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

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

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

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

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

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

HC-COV1397 01-24
ET

## The Schedule

The pharmacy schedule is amended to add the following:

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

SCHEDPHARM90-maet

# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

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

Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.

HC-EXC604 01-25
ET

## Termination of Insurance – Continuation

**Medical Insurance for Former Spouse**

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

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

**Effect of Remarriage of Employee**

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

**Special Continuations of Medical Insurance**

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

**Involuntary Layoff**

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

**Plant Closing**

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

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

**After Your Death**

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

**Other Dates of Termination**

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

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

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

**Special 31-Day Continuation**

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

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

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

HC-TRM18 04-10
V1-ET

## Definitions

**Dependent**

Dependents are:

- your former spouse, unless the divorce decree provides otherwise; or

A child includes:

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

HC-DFS1686 01-25

V1-ET

**Prescription Drug Product**

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

HC-DFS1831 01-24

ET

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

**CERTIFICATE RIDER –** Michigan Residents

Rider Eligibility: Each Employee who is located in Michigan

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

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

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

HC-ETMIRDR

**Important Notice**

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

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

- a telephone number to obtain additional information regarding the information described above.

HC-IMP392 01-24
ET

**Continuity Of Care**

You may request continuity of care with a provider for a period of time (a transitional period) if a provider ceases to be a Participating Provider.

The provider must agree that during the transitional period, the provider will: accept applicable reimbursement rates; adhere to Participating Provider standards for maintaining quality health care; provide necessary information to Cigna related to care provided during the transitional period; and adhere to Cigna's policies and procedures, including, but not limited to those related to utilization review, referrals, prior authorizations and treatment plans.

A transitional period is:

- for pregnancy/postpartum, second or third trimester and postpartum care directly related to delivery.
- for an ongoing course of treatment other than pregnancy/postpartum, 90 days from the date of notice of the provider's network termination.
- for a terminal condition, for the duration of the condition.

HC-IMP391 01-24
ET

# The Schedule

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

**Out-of-Network Emergency Services Charges**

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

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges that may be made in excess of the allowable amount, except as described above for services rendered in Michigan. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

The medical schedule is amended to add the following paragraph:

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

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

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

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

SCHEDMI-ETC

# The Schedule

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

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

"3 visits; the 3 visit limit does not apply to treatment of diabetes."

SCHEDMI ET1

## Covered Expenses

- charges for contraceptives. Prescription Drug Benefit terms and conditions apply to Prescription Drug Products.
- charges for treatment of autism spectrum disorders (pervasive developmental disorders) as defined in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM).
- charges for diabetes self-management training at initial diagnosis, and at significant changes in symptoms, conditions, or treatment.

**Virtual Care**

**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 (telemedicine) that are similar to office visit services provided in a face-to-face setting.

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

HC-COV1664 01-26
ET1

**Durable Medical Equipment**

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

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

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

HC-COV1509 01-24
ET

# Prescription Drug Benefits

## Limitations

**Prescription Eye Drops Refills**

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

(a) For a 30-day supply, once 23 days have passed after either of the following:

- The original date the prescription was distributed to you.
- The date the most recent refill was distributed to you.

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

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

HC-PHR375 01-20
ET

# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

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

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

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician relies on the coverage policies maintained by Cigna or the Review Organization. Coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines, and is recognized for the treatment of the prescribed indication in any one of the following: American Medical Association Drug Evaluation; American Hospital Formulary Service Drug Information; United States Pharmacopoeia Drug Information or any two articles from major peer-reviewed medical journals.
- charges for health care services, supplies, or medications when billed for conditions or diagnoses that are not covered or reimbursable under the coverage policies maintained by Cigna or the Review Organization.
- 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-EXC638 01-26
ET

# Definitions

**Emergency Services**

Emergency Services means, with respect to an Emergency Medical Condition:

- a medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition.
- such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or emergency department, as are required to Stabilize the patient (regardless of the Hospital department in which further examination or treatment is provided).
- after the patient is Stabilized, services rendered by an Out-of-Network provider, Hospital or facility (regardless of the Hospital department that provides the services) as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are provided.

  However, such post-Stabilization services are not considered Emergency Services if the attending provider determines the patient is able to travel using non-medical or non-emergency transportation to an available In-Network location within reasonable travel distance and applicable state and federal notice and consent requirements are met.

Coverage of an Emergency Service up to Stabilization cannot be denied solely based on the final diagnosis. Prior authorization is not required for Emergency Services.

HC-DFS1941 01-24
ET

**Prescription Drug Product**

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

- Certain durable products and supplies that support drug therapy;
- Certain diagnostic testing and screening services that support drug therapy;
- Certain medication consultation and other medication administration services that support drug therapy;
- Certain digital products, applications, electronic devices, software and cloud-based service solutions used to predict, detect and monitor health conditions in support of drug therapy; and
- For treatment of diabetes: non-experimental medication for controlling blood sugar, medication used in the treatment of the feet, ankles or nails associated with diabetes, insulin, pre-filled insulin pens and cartridges, insulin pump accessories (excluding insulin pumps), glucose test strips, visual reading and urine testing strips, lancets and spring-powered lancet devices, syringes.

HC-DFS1959 01-24
ET

# Definitions

**Prescription Drug Product**

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

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

HC-DFS1689 01-22
ET

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

**CERTIFICATE RIDER –** Minnesota Residents

Rider Eligibility: Each Employee who is located in Minnesota

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 Minnesota group insurance plans covering insureds located in Minnesota. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETMNRDR

**Special Plan Provisions**

MN Statute Section 62Q.56 provides as follows: If an enrollee is subject to a change in Health Plans, the enrollee's new Health Plan company must provide, upon request, authorization to receive services that are otherwise covered under the terms of the new Health Plan through the enrollee's current provider: 90 days of coverage during the first trimester of pregnancy for up to 120 days if the enrollee is engaged in a current course of treatment for one or more of the following conditions: an acute condition; a life-threatening mental or physical illness; a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or a disabling or chronic condition that is in an acute phase; or; for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

REINSTATEMENT. If any renewal premium be not paid within the time granted the Policyholder for payment, a subsequent acceptance of premium by the Insurance Company, or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. Provided, however that if the Insurance Company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by the Insurance Company or, lacking such approval upon the forty-fifth (45) day following the date of such conditional receipt unless the Insurance Company has previously notified the Policyholder in writing of disapproval of such application.

In all other respects the insured and Insurance Company shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed heron or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

NOTICE:

MN Statute Section 60A.084 (2000) provides as follows: An Employer providing life or health benefits may not change benefits, limit coverage, or otherwise restrict participation until the Certificate holder or enrollee has been notified of any changes, limitations, or restrictions. Notice in a format which meets the requirements of ERISA USCA, Title 29, Sections 1001-1461 is satisfactory for compliance with this section.

HC-SPP90 03-25

ET

# Eligibility - Effective Date

## Dependent Insurance

### Effective Date of Dependent Insurance

For your Dependents to be insured for these benefits, you must elect the Dependent insurance for yourself no later than 30 days after you become eligible. If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until Cigna agrees to insure that Dependent.

### Exception for Newborns

Any Dependent child, or grandchild who is financially dependent upon you and who resides with you continuously from birth, born while you are insured, will become insured on the date of his birth. Such coverage must consist of benefits for illness, injury, congenital malformation or premature birth. If additional premium is required, you are encouraged to pay the required premium no later than 31 days after the child or grandchild’s birth. If additional premium is required and you do not elect to insure your newborn child or dependent grandchild within such 31 days, Cigna may reduce the health benefits owed by the amount of the past due premium.

HC-ELG409 03-25

ET

# Certification Requirements - Out-of-Network

Mental health treatment covered under the plan which is court-ordered by a Minnesota court of competent jurisdiction

pursuant to a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment, shall be covered without being subject to Pre-Admission Certification (PAC). A copy of the court order and behavioral care evaluations must be provided to the Plan. (Minn. Stat. 62Q.535)

HC-PAC84 01-19
ET

### Prior Authorization/Pre-Authorized

Mental health treatment covered under the plan which is court-ordered by a Minnesota court of competent jurisdiction pursuant to a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment, shall be covered without being subject to prior authorization. A copy of the court order and behavioral care evaluations must be provided to the Plan. (Minn. Stat. 62Q.535)

HC-PRA81 03-25
ET

## The Schedule

The medical schedule is amended to add the provision "Hearing Aids".

**Hearing Aids**

One per ear Maximum per individual every 36 months

SCHED MN ET

## The Schedule

The following text replaces any such similar text in the "Abortion" provision in The Schedule of your medical certificate:

Includes elective and non-elective procedures

SCHED MN ET5

## The Schedule

The "External Prosthetic Devices" provision in The Schedule of your medical certificate is amended to indicate the following:

No separate External Prosthetic Devices maximum or separate deductible will apply. In addition, In-Network External Prosthetic Devices benefits are payable at no less than 80% coinsurance.

SCHED MN ET6

### Covered Expenses

- charges made for Rapid Whole Genome Sequencing ("rWGS") testing for persons age 21 years or younger that meet the medical necessity criteria requirements.
- charges for Biomarker Testing for the purposes of diagnosing, treating, appropriately managing, or monitoring a disease or condition if the test provides Clinical Utility.
- charges for abortions and abortion related services including pre-abortion and follow-up services.
- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage on oral contraceptives.
- charges made for hearing aids, including but not limited to semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound. Coverage is limited to one hearing aid per ear every three years.
- charges made for or in connection with the diagnosis and treatment of pediatric autoimmune neuropsychiatric disorders and pediatric acute-onset neuropsychiatric syndrome. Treatment includes but is not limited to antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, plasma exchange, and immunoglobulin.
- charges made for intermittent urinary catheters and insertion supplies.
- Additional coverage of post delivery care for mother and baby:
  - comprehensive postnatal visit with a Health Care Provider HCP not more than 3 weeks from the date of delivery;

- any postnatal visits recommended by a Health Care Provider HCP between 3 and 11 weeks from the date of delivery; and
- a comprehensive postnatal visit with a Health Care Provider HCP 12 weeks from the date of delivery.

A comprehensive postnatal visit means a visit with a Health Care Provider HCP that includes a full assessment of the mother's and infant's physical, social, and psychological well-being, including but not limited to: mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from birth; chronic disease management; and health maintenance.

**Rare Disease or Condition**

Charges for services related to the diagnosis, monitoring and treatment of a Rare Disease or Condition. Services include unrestricted access to where services from a Physician are received; this includes but is not limited to restrictions from the prior authorization process. If the subsequent diagnosis from a provider does not meet the definition of Rare Disease or Condition, the services provided by the provider will be covered In-Network for up to 60 days providing time for care to be transferred to a qualified In-Network provider. You may be billed for services provided by an Out-of-Network provider, who is outside the state of Minnesota, for an amount above what Cigna is required to pay the provider.

HC-COV1634 03-25
ET1

**Durable Medical Equipment**

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility.
- Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for, but not limited to, use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, ventilators, insulin pumps and wheel chairs.

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

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

If you have questions about your Durable Medical Equipment coverage, contact member services at the toll-free number on the back of your ID card.

HC-COV1106 01-21
ET

**Clinical Trials**

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

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

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered: it is a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that meets **any** of the following criteria:

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

  Or **any** of the following:
  - Department of Energy,
  - Department of Defense,
  - Department of Veteran's Affairs.

  If both of the following conditions are met:
  - 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.
  - 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 Food and Drug Administration.

The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

- services that are not considered routine patient care costs/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.
- hospital services.
- Physician services.
- office visits.
- room and board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

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

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

HC-COV1016 03-25
V1-ET

# The Schedule

The pharmacy Schedule is amended to indicate the following:

**Prescription Insulin Drugs**

Your cost share for each prescription insulin drug will not exceed $25 for a 30-day supply, $50 for a 60-day supply, or $75 for a 90-day supply regardless of the amount or type of insulin needed to fill the prescription during that interval.

**Prescription Drugs for Chronic Disease** (diabetes, asthma, allergies requiring epinephrine autoinjector**)**

Your cost share for each prescription drug will not exceed $25 for a 30-day supply, $50 for a 60-day supply, or $75 for a 90-day supply after deductible.

SCHEDPHARM90-mnet2

# Prescription Drug Benefits

## Limitations

### Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.

If coverage of a prescription drug is restricted through the use of a step therapy protocol, you and your provider can request a step therapy override which is accessible at the website shown on your ID card.

An override will be granted under the following conditions:

1. If, the required prescription drug under the step therapy protocol is cautioned according to the pharmaceutical manufacturer's prescribing information for the drug, a documented adverse event from a previous use, or a documented medical condition including a comorbid condition, which:
   - causes an adverse reaction;
   - decreases the ability to achieve or maintain reasonable functional daily activities;
   - cause physical or mental harm
2. If a trial of the required prescription drug, or a different drug in the same pharmacologic class or mechanism of action was previously covered by another health plan, and was adherent during such trial for a period of time to allow for a positive treatment outcome, and the prescription drug was discontinued due to lack of effectiveness or an adverse event. You may be required to try another drug in the same pharmacologic class or with the same mechanism of action if that therapy sequence is supported by evidence-based and peer-reviewed clinical practice guidelines, Food and Drug Administration label, or pharmaceutical manufacturer's prescribing information.
3. If you have received a positive therapeutic outcome on a prescription drug for the medical condition under consideration while on current or immediately preceding health plan, you received coverage for the prescription drug and the prescribing health care provider provides documentation that the change by the step therapy protocol is expected to be ineffective or cause harm.

You and your provider have the right to appeal a step therapy override denial. If the denial upheld, a request for step therapy override will be eligible for external review.

Step Therapy does not apply if the Prescription Drug Product is used to treat stage four advanced metastatic cancer; and use of the Prescription Drug Product is:

- consistent with the U.S. Food and Drug Administration approved indication; or a clinical practice guideline published or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer; and
- with clinical practice guidelines published by the National Comprehensive Care Network.

### Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

Coverage is included for a 12-month supply for any prescription contraceptive if a 12-month supply is prescribed by the prescribing health care provider.

HC-PHR582 01-24
ET1

## Prescription Drug Benefits

### Your Payments

Cigna shall approve coverage for an antipsychotic Prescription Drug Product not listed on the Prescription Drug List that is prescribed to treat an emotional disturbance or mental illness, as defined by 62Q.527 of the Minnesota Insurance Code, if the Physician prescribing such Prescription Drug Product:

- indicates to the dispensing Pharmacist that the Prescription Order or Refill must be dispensed as communicated; and
- certifies in writing Cigna or its Review Organization that the Physician has considered all equivalent Prescription Drug Products on the Prescription Drug List and has determined that the Prescription Drug Product prescribed will best treat the enrollee's condition.

However, Cigna shall not be required to approve coverage for an antipsychotic Prescription Drug Product if the Prescription Drug Product was removed from the Prescription Drug List for safety reasons.

HC-PHR820 03-25
ET

### Exclusions

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

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

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for regardless of U.S Food and Drug Administration (FDA) approval status.

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

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 any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biologicals used off-label.

HC-PHR821 01-26
ET

## Exclusions, Expenses Not Covered and General Limitations

### Exclusions and Expenses Not Covered

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

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

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for indication or
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.

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

reviewed, evidence-based scientific literature or guidelines. 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 any authoritative compendia as identified by the Medicare program for use in the determination of a medically accepted indication of drugs and biologicals used off-label.

- court-ordered treatment or hospitalization, unless treatment is for Mental Health and Substance Abuse Disorders or is prescribed by a Physician and is a covered service or supply under this plan.

HC-EXC632 03-25
ET1

# Termination of Insurance

## Employees

### Reinstatement of Insurance

If your coverage ceases because of active duty in: the armed forces of the United States, or the National Guard, the insurance for you and your Dependents will be reinstated after your deactivation, provided that:

- you apply for such reinstatement within 90 days after deactivation; and
- you are otherwise eligible.

Such reinstatement will be without the application of: a new waiting period, or a new pre-existing condition limitation. A new pre-existing condition limitation will not be applied to a condition that you or your Dependent may have developed while coverage was interrupted, excluding any condition that the Veterans Administration has determined to be military related. The remainder of a pre-existing condition limitation which existed prior to interruption of coverage may still be applied.

# Termination of Insurance

## Dependents

Your insurance for all of your Dependents will cease on the earliest date below, except in the event of your death (Refer to the section titled Dependent Insurance After Your Death):

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM233 03-25
ET1

# Definitions

### Biomarker

A characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including but not limited to known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include but are not limited to gene mutations, characteristics of genes, or protein expression.

HC-DFS2106 03-25
ET

### Biomarker Testing

The analysis of an individual's tissue, blood, or other biospecimen for the presence of a Biomarker. Biomarker testing includes but is not limited to single-analyst tests; multiplex panel tests; protein expression; and whole exome, whole genome, and whole transcriptome sequencing.

HC-DFS2107 03-25
ET

### Clinical Utility

At term that describes a test that provides information that is used to formulate a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision. The most appropriate test may include information that is actionable and some information that cannot be immediately used to formulate a clinical decision.

HC-DFS2108 03-25
ET

**Medically Necessary/Medical Necessity**

For mental health services, Medically Necessary/Medical Necessity means health care services appropriate, in terms of type, frequency, level, setting, and duration, to your diagnosis or condition, and diagnostic testing and preventive services. Medically Necessary care must be consistent with generally accepted practice parameters as determined by Health Care Providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

- help restore or maintain the enrollee's health; or
- prevent deterioration of the enrollee's condition.

In determining whether health care services, supplies, or medications are Medically Necessary, the Medical Director relies 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.

HC-DFS2088 03-25
ET

**Rapid Whole Genome Sequencing (rWGS)**

An investigation of the entire human genome, including coding and noncoding regions and mitochondrial deoxyribonucleic acid, to identify disease-causing genetic changes that returns the final results in 14 days. Rapid Whole Genome Sequencing includes patient-only whole genome sequencing and duo and trio whole genome sequencing of the patient and the patient's biological parent or parents.

HC-DFS2110 03-25
ET

**Rare Disease or Condition**

Any disease or condition:

(1) that affects fewer than 200,000 persons in the United States and is chronic, serious, life-altering, or life-threatening;

(2) that affects more than 200,000 persons in the United States and a drug for treatment has been designated as a drug for a rare disease or condition pursuant to United States Code, title 21, section 360bb;

(3) that is labeled as a rare disease or condition on the Genetic and Rare Diseases Information Center list created by the National Institutes of Health; or

(4) for which an enrollee:

- (i) has received two or more clinical consultations from a primary care provider or specialty provider that are specific to the presenting complaint;
- (ii) has documentation in the enrollee's medical record of a developmental delay through standardized assessment, developmental regression, failure to thrive, or progressive multisystemic involvement; and
- (iii) had laboratory or clinical testing that failed to provide a definitive diagnosis or resulted in conflicting diagnoses.

A rare disease or condition does not include an infectious disease that has widely available and known protocols for diagnosis and treatment and that is commonly treated in a primary care setting, even if it affects less than 200,000 persons in the United States.

HC-DFS1890 01-24
ET

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

**CERTIFICATE RIDER –** Mississippi Residents

Rider Eligibility: Each Employee who is located in Mississippi

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 Mississippi group insurance plans covering insureds located in Mississippi. These provisions supersede

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

HC-ETMSRDR

## Covered Expenses

- charges made for annual low-dose mammography screening for all women aged 35 or older.
- charges made for the surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) and craniomandibular joint disorders if prescribed by a Physician or a dentist, subject to the limitations stated in the "Exclusions, Expenses Not Covered and General Limitations" section. Coverage must be the same as for any other joint in the body.
- charges for services related to gender affirmation, excluding persons under the age of eighteen (18) as required under Mississippi Miss. Code Ann. § 83-9-36.1 to the extent such age limit is permissible under the federal Mental Health Parity and Addiction Equity Act, including behavioral counseling, hormone therapy, genital reconstructive surgical procedures, and chest reconstructive surgical procedures.

HC-COV1563 01-24 ET

# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

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

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

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.

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

  The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of the prescribed indication in US Pharmacopoeia Drug Information or American Hospital Formulary Service Drug Information, or in two articles from major peer-reviewed professional medical journals, unless two articles from major peer-reviewed journals have determined that the drug is unsafe or ineffective, or that drug safety and effectiveness cannot be determined for the prescribed treatment.

HC-EXC602 01-24 ET

# Termination of Insurance

### Special Continuation of Medical Insurance

If your insurance ceases due to termination of employment for any reason other than fraud or nonpayment of any required premium or, regarding a covered Dependent, the death of the Employee, divorce from the Employee, or failure of a Dependent child to qualify as a Dependent and:

- you or your Dependent has been insured under the policy (and any similar group coverage replaced by the policy) for at least 3 consecutive months immediately prior to the date of termination; and
- you or your Dependent is not eligible for other insured or uninsured coverage within 31 days following the date of termination; and
- you or your Dependent is not covered under Medicare, although a Dependent of an Employee who elects Medicare is eligible to continue coverage;

you or your Dependent may continue the insurance by paying the required premiums to the Policyholder. In no event will the insurance be continued beyond the earliest of the following dates:

- the expiration of 12 months from the date the insurance would otherwise terminate;
- the last day for which you or your Dependent has paid the required premium;
- the date you or your Dependent becomes eligible for insured or uninsured group medical coverage or elects Medicare, although a Dependent of an Employee who elects Medicare is eligible to continue coverage;
- the date the group policy is canceled; or
- the date a surviving or divorced spouse remarries and becomes covered for medical benefits under a health plan with no pre-existing condition limitations.

**Notice Requirements**

For Employees and Dependents upon termination of employment or ineligibility of Employee class, Cigna will send notice of the right to continue coverage prior to termination of coverage. For Dependents upon Employee death, Employee entitlement to Medicare, divorce, or loss of eligibility as a Dependent child, your Employer will send notice of the right to continue within 14 days after being notified of any event above. You must elect to continue coverage within 30 calendar days of receiving notice of the right to continue.

HC-TRM52 04-10
V1-ET

# Prescription Drug Benefits

## Limitations

### Supply Limits

You may synchronize a refill of a Prescription Drug Product with your other Prescription Drug Products, and pay a prorated copay or Coinsurance for the partial supply if filled by a Network Pharmacy, and under the following conditions:

- The prescriber or the pharmacist must determine that filling/refilling a prescription with a partial supply, for the purpose of synchronization, is in your best interest; and
- You either request or agree to the partial supply of the medication for the purpose of synchronization.

However, any dispensing fees must be paid in full for each partially filled/refilled prescription, regardless of your prorated, copay or Coinsurance.

HC-PHR583 01-23
ET

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

**CERTIFICATE RIDER –** Missouri Residents

Rider Eligibility: Each Employee who is located in Missouri

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 Missouri group insurance plans covering insureds located in Missouri. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETMORDR

# Important Notices

### Missouri First Steps Program

Cigna participates in Missouri’s Part C Early Intervention System, “First Steps”. “First Steps” provides coverage for Early Intervention Services described in this section that are delivered by early intervention specialists who are health care professionals licensed by the state of Missouri and acting within the scope of their professions for children from birth to age three identified by the Part C Early Intervention System as eligible services for persons under Part C of the Individuals with Disabilities Education Act.

Early Intervention Services means Medically Necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology devices for children from birth to age three who are identified by the Part C Early Intervention System as eligible for services under Part C of the Individuals with Disabilities Education Act and shall include services under an active individualized family service plan that enhances functional ability without effecting a cure. An individualized family service plan is a written plan for providing Early Intervention Services to an eligible child and the child's family that is adopted in accordance with 20 U.S.C. Section 1436.

**Missouri Utilization Review Decisions and Procedures**

For determinations, Cigna shall make the determination within two working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

- In the case of a determination to certify an admission, procedure or service, Cigna shall notify the provider rendering the service by telephone or electronically within 24 hours of making the certification, and provide written or electronic confirmation of a telephone or electronic notification to the covered person and the provider within two working days of making the certification;
- In the case of an adverse determination, Cigna shall notify the provider rendering the service by telephone or electronically within 24 hours of making the adverse determination; and shall provide written or electronic confirmation of a telephone or electronic notification to the covered person and the provider within one working day of making the adverse determination.

For concurrent review determinations, Cigna shall make the determination within one working day of obtaining all necessary information:

- In the case of a determination to certify an extended stay or additional services, Cigna shall notify by telephone or electronically the provider rendering the service within one working day of making the certification, and provide written or electronic confirmation to the covered person and the provider within one working day after telephone or electronic notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;
- In the case of an adverse determination, Cigna shall notify by telephone or electronically the provider rendering the service within twenty-four hours of making the adverse determination, and provide written or electronic notification to the covered person and the provider within one working day of a telephone or electronic notification. The service shall be continued without liability to the covered person until the covered person has been notified of the determination.

For retrospective review determinations, Cigna shall make the determination within thirty working days of receiving all necessary information. Cigna shall provide notice in writing of Cigna's determination to a covered person within ten working days of making the determination.

When conducting utilization review or making a benefit determination for emergency services, Cigna shall cover emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services. Before denying payment for an emergency medical service based on the absence of an emergency medical condition, Cigna shall review the enrollee’s medical record regarding the emergency medical condition at issue. If Cigna requests records for a potential denial where emergency services were rendered, the provider shall submit the record of the emergency services within 45 processing days. Such review shall be completed by a Missouri board-certified Physician. When a covered person receives an emergency service that requires immediate post evaluation or post stabilization services, Cigna shall provide an authorization decision within 60 minutes of receiving a request; if the authorization decision is not made within 60 minutes, such services shall be deemed approved.

A written notification of an adverse determination shall include the principal reason or reasons for the determination, including the clinical rational, and the instructions for initiating an appeal or reconsideration of the determination. Cigna shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to the provider and to any party who received notice of the adverse determination. Requests for appeal includes an appeal for coverage of Medically Necessary pharmaceutical prescriptions and durable medical equipment.

Cigna shall have written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. These procedures shall be made available to providers on Cigna's website or provider

portal. In cases where the provider or a covered person will not release necessary information, Cigna may deny certification of an admission, procedure or service.

If an authorized representative of Cigna authorizes the provision of health care services, Cigna shall not subsequently retract its authorization after the health care services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition, the health benefit plan terminates before the health care services are provided or the covered person's coverage under the health benefit plan terminates before the health care services are provided.

# Eligibility - Effective Date

## Dependent Insurance

### Exception for Newborns

Any Dependent child born while you are insured will become insured from the moment of his birth. The coverage for a newly born child shall consist of coverage for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. You must notify Cigna of the birth of the newly born child and pay any premium, if required, within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period. If an application or other form of enrollment is required by your Employer in order to continue coverage beyond the 31-day period after the date of birth, and you have notified Cigna of the birth, either orally or in writing, Cigna will, upon notification, provide you with all forms and instructions necessary to enroll the newly born child and will allow you an additional 10 days from the date the forms and instructions are provided in which to enroll the newly born child. If you do not notify Cigna of the birth of the newly born child and pay any premium, if required, within such 31 days, coverage for that child will end on the 31st day, and no benefits for expenses incurred beyond the 31st day will be payable.

# The Schedule

### Out-of-Network Charges for Certain Services

Charges for services furnished by an Out-of-Network provider in an In-Network facility while you are receiving In-Network services at that In-Network facility: (i) are payable at the In-Network cost sharing level; and (ii) the allowable amount used to determine the Plan's benefit payment is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. 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.

### Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-Participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.
3. The allowable amount used to determine the Plan's benefit payment when Out-of-Network Emergency Services result in an inpatient admission is the median amount negotiated with In-Network facilities.

**The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. 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 Schedule

**Note:**

An Out-of-Network provider may bill you for the difference between that provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance. Out-of-Network providers may not balance bill you for unanticipated out-of-network care for an emergency medical condition.

## Covered Expenses

- Coverage for low-dose mammography screening, including digital mammography and breast tomosynthesis, for any nonsymptomatic woman covered under such policy or contract which meets the minimum requirements of this section. Such coverage shall include at least the following: a baseline mammogram for women age 35 to 39, inclusive; a mammogram every year for women age 40 and over; a mammogram every year for any woman deemed by a treating Physician to have an above-average risk for breast cancer in accordance with the American College of Radiology guidelines for breast cancer screening; any additional or supplemental imaging, such as breast magnetic resonance imaging or ultrasound, deemed Medically Necessary by a treating Physician for proper breast cancer screening or evaluation in accordance with applicable American College of Radiology guidelines; and ultrasound or magnetic resonance imaging services, if determined by a treating Physician to be Medically Necessary for the screening or evaluation of breast cancer for any woman deemed by the treating Physician to have an above-average risk for breast cancer in accordance with American College of Radiology guidelines for breast cancer screening.
- Low Dose Mammography Screening means the x-ray examination of the breast using equipment specifically designed and dedicated for mammography, including the x-ray tube, filter, compression device, detector, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast, and any fee charged by a radiologist or other Physician for reading, interpreting or diagnosing based on such x-ray. 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 prescription orally administered anticancer medications that are used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected anticancer medications. Coverage of orally administered anticancer medication shall not be subject to any prior authorization, dollar limit, Copayment, Deductible, or other Out-of-Pocket expense that does not apply to intravenously administered or injected anticancer medication, regardless of formulation or benefit category determination by Cigna.
- charges for a drug that has been prescribed as Medically Necessary to treat an illness for which it has not been approved by the Food and Drug Administration (FDA). Such a drug must be covered provided: it is recognized in an established reference compendia such as the United States Pharmacopeia Drug Information, American Hospital Formulary Service, or any peer-reviewed medical literature: for the specific type of illness for which it has been prescribed or the drug has not been contraindicated by the FDA for the use prescribed.
- charges made by a Hospital or an ambulatory surgical facility for anesthesia for inpatient Hospital dental procedures for: a child under the age of five; a person with a severe disability; or a person with a behavioral or medical condition that requires hospitalization or general anesthesia when dental care is provided in a participating hospital, surgical center or office. Cigna may require prior authorization for hospitalization for dental procedures.
- charges for immunizations (including the associated office visit) for children from birth to five years of age as provided by department of health and senior services regulations . This includes the office visit in connection with immunizations. There will be no Deductible and no Copay.
- charges for or in connection with human leukocyte antigen testing, or histocompatibility locus antigen testing for A, B, and DR antigens for utilization in bone marrow transplantation when performed in a facility accredited by the American Association of Blood Banks or its successors, the College of American Pathologists, the American Society for Histocompatibility and Immunogenetics or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is licensed under the Clinical Laboratory Improvement Act.
- charges for or in connection with the diagnosis, treatment and appropriate management of osteoporosis for persons with a condition or medical history for which bone mass

measurement is Medically Necessary, provided such services are received by a Physician licensed to practice medicine and surgery in Missouri.

- charges for a colorectal examination and laboratory tests for cancer in accordance with current American Cancer Society guidelines for any nonsymptomatic person covered under the Plan.
- charges for a pelvic examination and Pap smear in accordance with current American Cancer Society guidelines for any nonsymptomatic woman covered under the Plan.
- charges for prostate cancer examinations and laboratory tests for any insured nonsymptomatic male, in accordance with current American Cancer Society guidelines. Men age 50 and older should discuss getting an annual PSA blood test and a digital rectal exam with their Physician. Men who are at risk, which includes African American or men who have a family history of prostate cancer, should consider being tested at a younger age.
- charges made by a Hospital or other facility that provides obstetrical care for inpatient Hospital services will include Covered Expenses for a mother and her newborn child for 48 hours following a vaginal delivery or for 96 hours following a cesarean delivery. A longer stay will be covered if deemed Medically Necessary. The mother may request an earlier discharge if, after consulting with her Physician, it is determined that less time is needed for recovery. If discharged early, at least 2 post discharge visits will be covered, one of which will be a home visit by either a registered Nurse with experience in maternal and child health nursing or a Physician. These visits will include, but are not limited to, a physical assessment of the mother and the newborn; parent education; assistance and training in breast and bottle feeding; education and services for complete childhood immunizations; Medically Necessary clinical tests; and the submission of a metabolic specimen to the state laboratory.

**Autism Spectrum Disorder and Applied Behavior Analysis**

Coverage is provided for the diagnosis and treatment of autism spectrum disorders, and care prescribed or ordered for a Member diagnosed with an autism spectrum disorder by a licensed Physician or licensed Psychologist, including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician's or licensed Psychologist's license, including but not limited to: psychiatric care; psychological care; habilitative or rehabilitative care, including behavior analysis therapy; therapeutic care; and pharmacy care. Coverage cannot be denied on the basis that it is educational or habilitative in nature. Benefits for the diagnosis and treatment of autism spectrum disorders are payable on the same basis as any other Sickness covered under the Plan.

**Other Developmental or Physical Disabilities**

Coverage is provided for the diagnosis and treatment of a developmental or physical disability, and care prescribed or ordered for a Member diagnosed with a developmental or physical disability by a licensed Physician or licensed Psychologist, including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician's or licensed Psychologist's license, including but not limited to: psychiatric care; psychological care; habilitative or rehabilitative care, excluding behavior analysis therapy; therapeutic care; and pharmacy care. Coverage cannot be denied on the basis that it is educational or habilitative in nature. Benefits for the diagnosis and treatment of developmental or physical disabilities are not subject to any age, dollar or visit limits.

The terms used above are defined as follows:

- **Autism spectrum disorders** means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- **Developmental or physical disability** means a severe chronic disability that:
  - is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness or autism spectrum disorder which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services; manifests before the individual reaches age nineteen; is likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activities:
  - self-care;
  - understanding and use of language;
  - learning;
  - mobility;
  - self-direction; or
  - capacity for independent living.

- **Diagnosis** means Medically Necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder or a developmental or physical disability.
- **Treatment** means care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed Physician or licensed Psychologist, or for an individual diagnosed with a developmental or physical disability by a licensed Physician or licensed Psychologist, including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician's or licensed Psychologist's license, including, but not limited to: psychiatric care; psychological care; habilitative or rehabilitative care, including applied behavior analysis therapy; for those diagnosed with autism spectrum disorder; therapeutic care; and pharmacy care.
- **Autism service provider** means any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst.
- **Applied behavior analysis** means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.
- **Habilitative or rehabilitative care** is professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual.
- **Line therapist** means an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.
- **Pharmacy care** means medications used to address symptoms of an autism spectrum disorder prescribed by a licensed Physician, and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications, only to the extent that such medications are included in the insured's health benefit plan.
- **Psychiatric care** means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- **Psychological care** means direct or consultative services provided by a Psychologist licensed in the state in which the Psychologist practices.
- **Therapeutic care** means services provided by licensed speech therapists, occupational therapists, or physical therapists.

**Diagnosis and Treatment of Eating Disorders**

Coverage is provided for the diagnosis and treatment of eating disorders when Medically Necessary, that is provided by a licensed treating Physician, psychiatrist, Psychologist, professional counselor, clinical social worker, or licensed marital and family therapist pursuant to the powers granted under such licensed Physician’s, psychiatrist’s, Psychologist’s, professional counselor’s, clinical social worker’s or licensed marital and family therapist license and acting within their applicable scope of coverage in accordance with a treatment plan. Medical Necessity determinations and care management shall consider the overall medical and mental health needs and not be based solely on weight, and shall take into consideration the most recent Practice Guidelines for the Treatment of Patients with Eating Disorders adopted by the American Psychiatric Association in addition to current standards based upon the medical literature generally recognized as authoritative in the medical community. The treatment plan, upon request by Cigna, shall include all elements necessary for Cigna to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

The terms used above are defined as follows:

- **Eating disorder**, Pica, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder, Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Other Specified Feeding or Eating Disorder, and any other eating disorder contained in the most recent version of the DSM of Mental Disorders published by the American Psychiatric Association where diagnosed by a licensed Physician, psychiatrist, Psychologist, clinical social worker, licensed marital and family therapist, or professional counselor duly licensed in the state where he or she practices and acting within their applicable scope of practice in the state where he or she practices;
- **Pharmacy care,** medications prescribed by a licensed Physician for an eating disorder and includes any health-related services deemed Medically Necessary to determine

the need or effectiveness of the medications, but only to the extent that such medications are included in the insured's health benefit plan;

- **Treatment of eating disorders**, therapy provided by a licensed treating Physician, psychiatrist, Psychologist, professional counselor, clinical social worker, or licensed marital and family therapist pursuant to the powers granted under such licensed Physician's, psychiatrist's, Psychologist's, professional counselor's, clinical social worker's, or licensed marital and family therapist's license in the state where he or she practices for an individual diagnosed with an eating disorder.

**Cancer Diagnosis Second Opinion**

Charges made for second opinion rendered by a Specialist in that specific cancer diagnosis area when a patient with a newly diagnosed cancer is referred to such Specialist by his or her attending Physician. Such benefits will be payable the same as other covered services. When an authorization for a second opinion from a non-Participating Provider has been obtained because a Participating Provider was not available to provide the second opinion, In-Network cost-sharing will apply.

**Clinical Trials**

Charges made for routine patient services incurred as the result of the phase II, III, or IV of a clinical trial that is associated with the prevention, early detection, or treatment of cancer.

Phase III and IV of a clinical trial must be approved by one of the following entities:

- one of the National Institutes of Health (NIH);
- an NIH Cooperative Group or Center;
- the FDA in the form of an investigational new drug application;
- the federal Departments of Veterans' Affairs or Defense;
- an institutional review board in the State of Missouri that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CRF 46); or
- a qualified research entity that meets the criteria for NIH Center support grant eligibility.

Phase II of a clinical trial; the clinical trial must be:

- approved by the National Institutes of Health (NIH), or
- approved by the National Cancer Institute Center, and be conducted at an academic or National Cancer Institute Center.

Additionally, the person must be actually enrolled in the clinical trial and not just applying the clinical trial protocol for Phase II.

Covered Expenses include drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient’s particular condition, including coverage for reasonable and Medically Necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

Routine patient services shall include coverage for reasonable and Medically Necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient services include all items and services that are not otherwise generally available to a qualified individual that are provided in the clinical trial except:

- the investigational item, service or supply itself;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management of the patient; and
- items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

**Hearing Aids for Children**

Coverage will be provided for one Medically Necessary hearing aid per ear for children through age 17 every four years. Such coverage related services (testing, earmold, fitting, dispensing, and postfitting evaluation) will be provided at no cost to you. Any hearing aid for the purpose of binaural amplification must be prescribed by an otolaryngologist, otologist, or otorhinolaryngologist.

- charges for virtual care will be covered on the same basis as covered services provided through a face to face diagnosis, consultation, treatment or contact with a Participating Provider. Coverage does not include virtual care site origination fees or costs for the provision of virtual care services. Utilization may be utilized to determine the appropriateness of virtual care as a means of delivering a health care service on the same basis as when the same service is delivered in person.

**Outpatient Therapy Services**

**Chiropractic Care Services**

- charges for diagnostic and treatment services by chiropractic Physicians. The practice of chiropractic is defined as the science and art of examination, diagnosis, adjustment, manipulation and treatment both in inpatient and outpatient settings and may include meridian therapy/acupressure/acupuncture with certification as required by the board. For these services you have direct access to qualified chiropractic Physicians.

A Copayment that exceeds fifty percent of the total cost of providing any single chiropractic service to a covered person will never be imposed.

Coverage is provided when Medically Necessary in the most medically appropriate setting to:

- restore function (called “rehabilitative”):
  - to restore function that has been impaired or lost.
  - to reduce pain as a result of Sickness, Injury, or loss of a body part.
- improve, adapt or attain function (sometimes called “habilitative”):
  - to improve, adapt or attain function that has been impaired or was never achieved as a result of congenital abnormality (birth defect).
  - to improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions. Includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.

Coverage is provided as part of a program of treatment when the therapy is provided by, or under the direct supervision of, a licensed health care professional acting within the scope of the license and is Medically Necessary and medically appropriate for the diagnosed condition.

Coverage for occupational therapy is provided only for purposes of enabling individuals to perform the activities of daily living after an Injury or Sickness.

Therapy services that are not covered include:

- sensory integration therapy.
- treatment of dyslexia.
- maintenance or preventive treatment provided to prevent recurrence or to maintain the patient’s current status.
- vitamin therapy.

Coverage is administered according to the following:

- multiple therapy services provided on the same day constitute one day of service for each therapy type.
- a separate Copayment applies to the services provided by each provider for each therapy type per day.

**Chiropractic Care Services**

Charges made for the science and art of examination, diagnosis, adjustment, manipulation and treatment both in inpatient and outpatient settings, by those methods commonly taught in any chiropractic college or chiropractic program in a university which has been accredited by the Council on Chiropractic Education, its successor entity or approved by the board. It shall not include the use of operative surgery, obstetrics, osteopathy, podiatry, nor the administration or prescribing of any drug or medicine nor the practice of medicine.

The practice of chiropractic may include meridian therapy/acupressure/acupuncture with certification as required by the board.

A copayment that exceeds fifty percent of the total cost of providing any single chiropractic service to a covered person will never be imposed.

## Medical Conversion Privilege

**For You and Your Dependents**

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

A Converted Policy will be issued by Cigna only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to Cigna within 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 timely paid all required premium or contribution.

- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- the group policy terminated and the insurance is replaced by similar coverage under another group policy within 31 days of the date of termination.
- you are not eligible for Medicare.
- you are not or could not be covered for similar benefits by another individual policy; or you are not or could not be covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured; or similar benefits are not provided to or available to you, by reason of any state or federal law, which result in you being Overinsured.

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**

Any Dependent covered by the group policy on the date of termination of insurance is entitled to convert, but only if that Dependent has timely paid all required premium or contribution; is not eligible for Medicare; and would not be Overinsured.

**Overinsured**

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

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

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

**Converted Policy**

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

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

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.

# Prescription Drug Benefits

## Covered Expenses

Your plan provides benefits for Prescription Drug Products on the Prescription Drug List dispensed by a Pharmacy. Prescription Drug Products include prescribed orally administered anticancer medications. Details regarding your plan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations and Exclusions are provided below and/or are shown in The Schedule.

**Prescription Drug List Management**

Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. Determination of inclusion of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and utilization management requirements or other coverage conditions are based on a number of factors which may include, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in

therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

Carriers must notify customers presently taking a prescription drug of the deletion of the drug from the formulary at least 30 days prior to the deletion. The notification shall be electronic or in writing, upon request of the enrollee.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy (ies) for coverage, or try another covered Prescription Drug Product(s). Please access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

# Prescription Drug Benefits

## Limitations

### Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed. If a Prescription Drug Product is prescribed in a single dosage amount for which it is not manufactured in such single dosage amount and requires dispensing the particular Prescription Drug Product in a combination of different manufactured dosage amounts, only one copay for the dispensing of the combination of manufactured dosages that equal the prescribed dosage will be applied. Such copay requirement shall not apply to prescriptions in excess of a one-month supply.

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

Coverage for the refilling of an eye drop prescription prior to the last day of the prescribed dosage period without regard to a coverage restriction for early refill of prescription renewals as long as the prescribing health care provider authorizes such early refill, and the health carrier or the health benefit plan is notified will be provided.

**Synchronization of Prescription Drug Orders or Refills:**

Prescription drug coverage shall provide for synchronization of prescription drug refills.

Cigna shall:

- not charge an amount in excess of the otherwise applicable co-payment amount under the plan for dispensing a prescription drug in a quantity that is less than the prescribed amount if the Pharmacy dispenses the prescription drug in accordance with the medication synchronization services offered under the Plan and a Participating Provider dispenses the prescription drug; and
- provide a full dispensing fee to the pharmacy that dispenses the prescription drug to the covered person.

# 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 either:

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.

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

- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for a continuous course of dental treatment for an accidental Injury to teeth are covered. Additionally, charges made by a Hospital or an ambulatory surgical facility for anesthesia for inpatient Hospital dental procedures for: a child under the age of five; a person with a severe disability; or a person with a behavioral or medical condition that requires hospitalization or general anesthesia when dental care is provided in a participating Hospital, surgical center or office are covered.
- non-medical counseling and/or ancillary services, including but not limited to Custodial Services, educational services, vocational counseling training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.

# Termination of Insurance

### Employees and Dependents When not Eligible for Federal Cobra

### For Dependents of Deceased Employee

If you die while insured, your Dependents who are insured at the time of your death may continue their insurance by paying the required contribution to the Policyholder, but in no event beyond the earliest of the following dates:

- the expiration of 9 months from the date of your death;
- the last day of the period for which the required contribution has been paid;
- the date your insurance would otherwise have terminated as provided in the Special Continuation of Medical Insurance For Employees section;
- with respect to any one Dependent, the date that Dependent becomes eligible for similar group coverage;
- the date this policy cancels.

### For Spouse Upon Divorce From Employee

If your divorced or legally separated spouse's insurance would otherwise terminate because of divorce, legal separation or annulment of marriage, your divorced or legally separated spouse who is fifty-five years of age or older may continue the insurance upon the expiration of coverage provided by the federal COBRA by paying the required contribution to the Policyholder, but in no event beyond the earliest of the following dates:

- the last day of the period for which the required contribution has been paid;
- the date that your divorced or legally separated spouse becomes insured under another plan;
- the date your divorced or legally separated spouse attains their sixty-fifth birthday;
- the date this policy cancels.

# Definitions

### Emergency Services

Emergency Services means, with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical

Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or emergency department, as are required to Stabilize the patient.

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

**CERTIFICATE RIDER –** New Hampshire Residents

Rider Eligibility: Each Employee who is located in New Hampshire

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

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

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

HC-ETNHRDR

# Notice

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

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**Important Information**

**Rebates and Other Payments**

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

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

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**New Hampshire Patient Bill of Rights**

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

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

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

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

IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) Visitors are noncompliant with written hospital policy.

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

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

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

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

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

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

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

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

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

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

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

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

HC-IMP333 01-23
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# Eligibility - Effective Date

**Late Entrant - Employee**

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

## Dependent Insurance

**Late Entrant – Dependent**

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

**Exception for Newborns**

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

**Exception for Newborn Grandchildren**

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

HC-ELG361 01-23

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# The Schedule

The following supersedes any similar provisions shown in your medical schedule of your medical certificate:

**Fertility Services**

Coverage is provided In-Network (and Out-of-Network, if your plan includes Out-of-Network coverage) for the following services:

- diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed.

Any applicable cost share amount that you are required to pay is based on place of service.

**Treatment Per Lifetime Maximum:**

Unlimited

SCHED NH ET

## Certification Requirements – Out-of-Network

**For You and Your Dependents**

**Pre-Admission Certification/Continued Stay Review for Hospital Confinement**

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

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

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

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

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

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

**Outpatient Certification Requirements – Out-of-Network**

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

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

HC-PAC119 01-20

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## The Schedule

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

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

"3 visits; the visit limit does not apply to treatment of diabetes."

SCHEDNH ET1

## Prior Authorization/Pre-Authorized

Services that require Prior Authorization include, but are not limited to:

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

HC-PRA76 01-25
V1-ET

## Covered Expenses

- charges for cancer screening blood tests; Perfluoroalkyls (PFAS) and Perfluorinated Compound (PFC).
- charges made for blood lead testing including follow up testing, for children under ages 1 and 2.
- coverage for long-term antibiotic therapy for tick-borne illness when determined to be Medically Necessary and ordered by a licensed infectious disease Physician after making a thorough evaluation of the patient's symptoms, diagnostic test results or response to treatment.
- charges for all necessary medical examinations, imaging studies, and tests required to make a gestational age determination prior to an abortion.
- charges made for treatment of the diseases and ailments caused by obesity and morbid obesity, including bariatric surgery. The insured's prescribing Physician must issue a written order stating that treatment is Medically Necessary and in accordance with the patient qualifications and treatment standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. The covered insured must be at least 18 years of age.
- charges made for the professional services associated with the practice of fitting, dispensing, service or sale of hearing instruments or hearing aids by a hearing instrument dispenser or other hearing care professional. Coverage includes the cost of a hearing aid for each ear, as needed, as well as related services necessary to assess, select, and fit the hearing aid. An insured person may choose a higher-priced hearing aid, and pay the difference in the cost. Hearing aids must be prescribed 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 laboratory fee expenses arising from human leukocyte antigen testing (also referred to as histocompatibility locus antigen testing) for utilization in bone marrow transplantation, up to $150. The testing facility may not bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a covered person or a person acting on behalf of a covered person for any portion of the laboratory fee expenses.
- charges for 48 hours inpatient stay following a vaginal delivery or 96 hours following a cesarean section. An earlier discharge may be determined by the mother and attending Physician. An additional length of stay will be covered if deemed Medically Necessary.

  If discharge is prior to the 48/96 hours, at least 2 postpartum visits will be provided if the service is by a licensed Physician with experience in perinatal care. Postpartum visits shall include a physical assessment of mother and infant. The assessment shall include but not be limited to: infant nutrition and feeding, infant behavior, family interactions, safety and injury prevention, infant and maternal health promotion, and community resources. Providers of postpartum visits shall be licensed health care providers experienced in perinatal care.
- charges for Medically Necessary prenatal and/or postpartum homemaker services when a woman is confined to bed rest or her daily activities are restricted by her provider.
- charges being provided in a licensed health care facility or at home and within the scope of practice of a certified midwife.

- charges made by a Hospital or an Ambulatory Surgical Facility for general anesthesia administered by a licensed anesthesiologist or anesthetist for dental procedures for: a child under the age of 13 who is determined by a licensed dentist in conjunction with a licensed Physician to have a dental condition of significant dental complexity which requires certain dental procedures to be performed in an Ambulatory Surgical Facility or Hospital setting; or an individual with a developmental disability or exceptional medical circumstances, as determined by a licensed Physician, which place the person at serious risk.
- charges made for treatment of Biologically-Based Mental Illness, including: schizophrenia and other psychotic disorders; schizoaffective disorder; major depressive disorder; bipolar disorder; anorexia nervosa and bulimia nervosa; obsessive-compulsive disorder including pediatric autoimmune neuropsychiatric disorders, when treatment, including the use of intravenous immunoglobulin therapy; panic disorder; pervasive developmental disorder or autism; or chronic post-traumatic stress disorder. Such Covered Expenses will be payable the same as for other illnesses. Any exceptions or limitations for mental illness shown in The Schedule will not apply to Biologically-Based Mental Illness.
- charting for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech language pathologists, and clinical social workers working with children from birth to age 3 with an identified developmental disability and/or delay as long as the providing therapist receives a referral from the child's Primary Care Physician, if applicable.
- charges for scalp hair prostheses worn for hair loss suffered as a result of alopecia areata, alopecia totalis, alopecia medicamentosa resulting from the treatment from any form of cancer or leukemia including the treatment of breast cancer by autologous bone marrow transplants, or permanent loss of scalp hair due to injury. Such coverage will be subject to a written recommendation by the treating Physician indicating that the hair prosthesis is a medical necessity. Scalp hair prostheses means artificial substitutes for scalp hair that are made for a specific individual.
- charges for a drug that has been prescribed for a specific indication for which use of the drug has not been approved by the U.S. Food and Drug Administration (U.S. FDA). Such drugs will be covered if: the drug is recognized for treatment of the specific indication in one of the standard reference compendia or in medical literature as recommended by the American Medical Association; it has been otherwise approved by the FDA; and it has not been contraindicated by the U.S. FDA for the use prescribed. Coverage will also be provided for any medical services necessary to administer the drug.
- charges for Medically Necessary services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists and clinical social workers provided to a child with an identified developmental disability and/or delay, as long as the providing therapist receives a referral from the child's Primary Care Physician, if the plan requires such referral.
- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage on oral contraceptives.
- charges for Medically Necessary diabetic equipment and outpatient self-management training and educational services.

**Virtual Care**

**Dedicated Virtual Providers**

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

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

**Virtual Physician Services**

Includes charges for the delivery of real-time medical and health-related services by dedicated virtual providers and as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.

- Includes charges 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.

Includes charges for the delivery of real-time mental health and substance use disorder consultations and services via secure telecommunications technologies that shall include

video capability, telephones and internet, when such consultations and services are delivered by a behavioral provider and are similar to office visit services provided in a face-to-face setting. Coverage does not include services provided by telephone alone.

**Enteral Nutrition**

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

Coverage includes nonprescription enteral formulas and food products for the treatment of impaired absorption of nutrients caused by disorders of the gastrointestinal tract or inherited diseases of amino or organic acids. The Physician must issue a written order stating the enteral formula or food product is needed to sustain life, in the case of malabsorption, medically necessary, and the least restrictive and most cost-effective means for meeting the needs of the insured. Coverage for inherited diseases of amino and organic acids will, in addition to the enteral formula, include food products modified to be low protein.

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

HC-COV1600 01-25 ET

**Mental Health and Substance Use Disorder Services**

The plan covers charges for mental health and substance use disorder services rendered by psychiatrists, licensed psychologists, licensed pastoral psychotherapists, psychiatric/mental health advanced registered nurse practitioners, licensed clinical mental health counselors, licensed alcohol and drug counselors, licensed marriage and family therapists, licensed clinical social workers, and licensed psychiatrist-supervised physician assistants.

**Mental Health Disorders** are conditions which consider the following factors as defined in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM):

- a behavioral or psychological syndrome or pattern that occurs in an individual.
- reflects an underlying psychobiological dysfunction.
- the consequences of which are clinically significant distress (such as a painful symptom) or disability (such as impairment in one or more important areas of functioning).
- must not be merely an expected response to common stressors and losses (such as loss of a loved one) or a culturally sanctioned response to a particular event (such as trance states in religious rituals).
- primarily a result of social deviance or conflicts with society.

**Substance Use Disorders** involve patterns of symptoms caused by using a substance that an individual continues taking despite its negative effects, considering the following factors as defined in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM):

- using more of a substance than intended or using it for longer than a person is meant to use it.
- trying to cut down or stop using the substance, but unable to do so.
- experiencing intense cravings or urges to use the substance.
- needing more of the substance to get a desired effect, also referred to as tolerance.
- developing withdrawal symptoms when not using the substance.
- spending more time getting and using drugs and recovering from substance use.
- neglecting responsibilities at home, work, or school because of substance use.
- continuing to use the substance despite the substance causing problems to physical or mental health.
- giving up important or desirable social and recreational activities due to substance use.
- using substances in risky settings that put you or your Dependent in danger.

**Inpatient Mental Health Services (including Mental Health Acute Inpatient Services and Mental Health Residential Treatment Services)**

**Mental Health Acute Inpatient Services** are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Mental Health Disorder.

Following Hospital completion of an involuntary admission certificate for a patient, meeting state required criteria, the insurer shall pay the acute care Hospital a per diem day rate

required to board and care for the patient, to be contracted between the insurer and acute care Hospital, for each day the insured is waiting in an acute care medical Hospital located in the state admission for psychiatric treatment at New Hampshire Hospital, a community-based designated receiving facility, or a voluntary admission. The day rate required to board and care for the patient may be billed for up to 21 consecutive days or discharge, whichever is sooner, and shall be renewed as needed for patient protection. Mental health services provided in this setting under this section shall be deemed Medically Necessary and shall not require prior authorization.

**Mental Health Residential Treatment Services** are services provided by a Hospital or Mental Health Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for the evaluation and treatment of a subacute Mental Health Disorder.

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

**Outpatient Mental Health Services (including Mental Health Partial Hospitalization and Mental Health Intensive Outpatient Services)**

**Outpatient Mental Health Services** are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Mental Health Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Mental Health Residential Treatment Center, for evaluation and treatment of a Mental Health Disorder.

**Mental Health Partial Hospitalization Services** are active, time-limited, ambulatory mental health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Mental Health Disorders, similar in intensity to that provided in an Inpatient Hospital or Mental Health Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

**Mental Health Intensive Outpatient Services** are active, time-limited, ambulatory mental health treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Mental Health Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

**Inpatient Substance Use Disorder Services (including Acute Inpatient Detoxification, Substance Use Disorder Inpatient Rehabilitation, Substance Use Disorder Residential Treatment Services)**

**Acute Inpatient Detoxification Services** are services provided by a Hospital or Substance Use Disorder Residential Treatment Center for around-the-clock, intensive management and monitoring of individuals requiring acute detoxification as the initial phase of evaluation and treatment for a Substance Use Disorder.

**Substance Use Disorder Inpatient Treatment Services** are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Substance Use Disorder.

**Substance Use Disorder Residential Treatment Services** are services provided by a Hospital or Substance Use Disorder Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for evaluation and treatment of a subacute Substance Use Disorder.

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

**Outpatient Substance Use Disorder Rehabilitation Services (including Outpatient Detoxification, Substance Use Disorder Partial Hospitalization, and Substance Use Disorder Intensive Outpatient Services)**

**Outpatient Substance Use Disorder Services** are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Substance Use Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Substance Use

Disorder Residential Treatment Center, for evaluation and treatment of a Substance Use Disorder.

**Substance Use Disorder Partial Hospitalization Services** are active, time-limited, ambulatory substance use disorder treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Substance Use Disorders, similar in intensity to that provided in an Inpatient Hospital or Substance Use Disorder Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

**Substance Use Disorder Intensive Outpatient Services** are active, time-limited, ambulatory substance use disorder treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Substance Use Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

**Substance Use Disorder Detoxification Services** are services provided for daily, active comprehensive management and monitoring of individuals requiring detoxification as part of evaluation and treatment of a Substance Use Disorder, but that do not require a person to be Confined in a Hospital or Substance Use Disorder Residential Treatment Center.

HC-COV1601 01-25 ET

### Fertility Services

Charges made for services related to:

- diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed.
- Access reproductive services for the purposes of short term fertility preservation when an infertility condition is imminent.

Services include, but are not limited to: injectable fertility drugs which are administered or provided by a Physician; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; intrauterine insemination /artificial insemination; diagnostic evaluations; assisted reproductive techniques (ART) including in vitro fertilization (IVF); and the services of an embryologist.

Oral fertility drugs and injectable fertility drugs are covered under the Pharmacy benefit.

Infertility is defined as:

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

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

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, donor services, and donor eggs, sperm, and embryos;
- Pre-implantation genetic material and pre-implantation genetic material and pre-implantation genetic screening (PGS/PGT-A) of parents/donors beyond what is covered by the medical plan.

HC-COV1602 01-25 ET

### Clinical Trials

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

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

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

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

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

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

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

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

Examples of routine patient care costs and services include:

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

HC-COV1016 01-21
ET

# The Schedule

The pharmacy schedule is amended to add the following:

**Oral Chemotherapy Medication**

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

SCHEDPHARM90-nhet

# Prescription Drug Benefits

## Covered Expenses

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). Written notification of changes to the plan list or formulary such as: additions or deletions as will be provided annually. Please access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, explanation of the exemption process by which to access non-formulary Medically Necessary prescription drugs, or other coverage limitations for a Prescription Drug Product.

HC-PHR792 01-25 ET

# Prescription Drug Benefits

## Limitations

### Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors. Prior authorization requests must be responded to within 2 business days from the date the request is received.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the diagnosis and the Prescription Drug Product. 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 Product

has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

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

**Supply Limits**

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

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

**Prescription Eye Drops**

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

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

**Hormonal Contraceptive Drugs**

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

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

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

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

**Medication Synchronization**

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

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

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

Upon your request, the prescribing provider or pharmacist shall:

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

Prescription drug coverage shall provide for medication synchronization for an insured if all of the following conditions are met:

- the insurer must apply a prorated, daily cost-sharing rate to covered prescriptions dispensed by an In-Network pharmacy;
- the insurer must not reimburse or pay any dispensing fee that is prorated. The insurer must only pay or reimburse a dispensing fee that is based on each maintenance-prescription drug dispensed.

To be eligible a drug must:

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

HC-PHR793 01-25
ET

# Prescription Drug Benefits

## Exclusions

- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
- medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization,

biological sera, blood, blood plasma and other blood products or fractions unless specifically identified on the Prescription Drug List.

HC-PHR791 01-25
ET

## Exclusions, Expenses Not Covered and General Limitations

- 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 either:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician relies on the coverage policies maintained by Cigna or the Review Organization. Coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.
- the following services are excluded, unless Medically Necessary, except as may be covered under the “Reconstructive Surgery” benefit: macromastia (abnormal largeness of a woman’s breasts) surgery or gynecomastia (abnormal enlargement of a man’s breasts) surgery; surgical treatment of varicose veins (enlarged veins that are swollen and raised above the surface of the skin); abdominoplasty (plastic surgery of the abdomen in which excess fatty tissue and skin are removed, usually for cosmetic purposes); panniculectomy (surgical excision of the abdominal apron of superficial fat in the obese); rhinoplasty (plastic surgery of the nose); blepharoplasty (plastic surgery of the eyelids).
- the following services are excluded from coverage regardless of clinical indications: redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) except for Medically Necessary orthognathic surgery and craniofacial muscle disorders.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs. (See the Covered Expenses section of this certificate for information regarding coverage of scalp hair prostheses).

HC-EXC614 01-25
ET

## Continuation of Coverage Under New Hampshire State Law

### Continuation of Medical Insurance – Employee

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

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

**Continuation of Medical Insurance — Disabled Individuals**

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

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

**Continuation of Medical Insurance – Former Spouse**

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

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

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

**Continuation of Medical Insurance — Dependent**

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

For a Dependent child:

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

For a spouse who is under age 55:

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

For a spouse who is age 55 or over:

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

Notification and Election

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

**Continuation of Medical Insurance – Group Plan Termination**

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

- 39 weeks from the date group coverage is canceled;
- the date the person fails to make a timely premium payment;
- the date the person becomes eligible for benefits under another group plan or under Medicare; or

- the date your Dependent ceases to qualify as a Dependent under the provisions of the plan.

Notification and Election

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

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

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

**Special Continuation of Medical Insurance - Strike**

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

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

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

HC-TRM180 08-22

V1-ET

## Medical Benefits Extension Upon Policy Cancellation

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

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

**Totally Disabled**

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

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

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

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

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

HC-BEX29 04-10

V1-ET

## Definitions

**Dependent**

Dependents include:

- your lawful spouse of the same or opposite sex.

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

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

HC-DFS1731 01-23

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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 01-23
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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 04-10
V1-ET

**Prescription Drug Product**

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

- Certain durable products and supplies that support drug therapy;
- Certain diagnostic testing and screening services that support drug therapy;
- Certain medication consultation and other medication administration services that support drug therapy;
- Medically Necessary and appropriate diabetic supplies;
- Certain digital products, applications, electronic devices, software and cloud-based service solutions used to predict, detect and monitor health conditions in support of drug therapy.

HC-DFS1829 01-24
ET

**Primary Care Physician**

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

HC-DFS1753 01-23
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## CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

**CERTIFICATE RIDER –** New Jersey Residents

Rider Eligibility: Each Employee who is located in New Jersey

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 Jersey group insurance plans covering insureds located in New Jersey. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNJRDR

# Important Notice

Your health plan provides that you will not be held financially liable for payments to health care providers for any sums, other than required copayments, coinsurance or deductibles, owed for covered expenses, if Cigna fails to pay for the covered expenses for any reason.

HC-IMP17 04-10
V1-ET

# Payment of Benefits

**Calculation of Covered Expenses**

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

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

HC-POB108 01-17
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# Definitions

**Dependent**

Dependents include:

- your lawful spouse or civil union partner; or
- any child of yours who is:
  - less than 26 years old.
  - 26 years old, but less than 26, not married nor in a civil union partnership nor in a Domestic Partnership, enrolled in school as a full-time student and primarily supported by you.
  - 26 or more years old, not married nor in a civil union partnership nor in a Domestic Partnership, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this plan, or while covered as a Dependent under a prior plan with no break in coverage.

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

The term child means a child born to you or a child legally adopted by you; a child for whom you are responsible for pursuant to a court order; or your grandchild who is in your court ordered custody. It also includes a stepchild. If your civil union partner has a child, that child will also be included as a Dependent.

The term civil union means the legally recognized union of two eligible individuals of the same sex.

HC-DFS1730 01-24
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**Medically Necessary/Medical Necessity**

Medically Necessary Covered Services and Supplies means or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury or disease.

HC-DFS113 04-10
V1-ET

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

**CERTIFICATE RIDER –** New York Residents

Rider Eligibility: Each Employee who is located in New York

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

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

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

HC-ETNYRDR

# SECTION X. Additional Benefits, Equipment and Devices

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

**Enteral Nutrition**

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

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

# SECTION XI. Inpatient Services

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

**A. End of Life Care.**

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

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

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

HC-COV1714 01-25

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# SECTION XIII. Prescription Drug Coverage

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

**A. Covered Prescription Drugs.**

Covered Prescription Drugs include, but are not limited to:

- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to: inherited diseases of amino acid or organic acid

metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include, but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.

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

HC-PHR853 01-25
ET

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

**CERTIFICATE RIDER –** North Carolina Residents

Rider Eligibility: Each Employee who is located in North Carolina

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

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

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

HC-ETNCRDR

**Important Information**

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

**Coupons, Incentives and Other Communications**

If Cigna determines that a Pharmacy, pharmaceutical manufacturer or other third party is or has waived, reduced, or forgiven any portion of the charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Prescription Drug Product without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of plan benefits in connection with the Prescription Drug Product, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the Pharmacy, pharmaceutical manufacturer or other third party represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by the plan.

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

HC-IMP442 01-24
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# Eligibility - Effective Date

## Dependent Insurance

**Exception for Newborns**

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days,

coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

HC-ELG243 01-19
ET

## Covered Expenses

- charges for general anesthesia and associated Hospital or ambulatory surgical facility charges in connection with dental procedures for:
  - a child who is eight years or younger;
  - individuals with serious mental or physical conditions; and
  - individuals with significant behavioral problems.

  The treating provider must certify that hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.
- charges for the treatment of congenital defects or abnormalities, including necessary treatment and care of cleft lip or cleft palate.
- charges for a qualified individual for approved bone mass measurement (BMM) for the diagnosis and evaluation of osteoporosis or low bone mass, if at least 23 months have elapsed since the last measurement was performed. More frequent follow-up measurements will be covered when deemed Medically Necessary.

  **Bone Mass Measurement (BMM)** means a scientifically proven radiologic, radioisotopic, or other procedure performed on a qualified person to identify bone mass or detect bone loss in order to initiate or modify treatment.

  **A Qualified Person** means one who:
  - is estrogen deficient and at clinical risk for osteoporosis or low bone mass;
  - is experiencing radiographic osteopenia anywhere in the skeleton;
  - is receiving long-term glucocorticoid (steroid) therapy;
  - is having primary hyperparathyroidism;
  - is being monitored to assess the response to commonly accepted osteoporosis drug therapies;
  - has a history of low-trauma fractures;
  - has other conditions or is on medical therapies known to cause osteoporosis or low bone mass.
- charges made for surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) excluding orthodontic treatment.

HC-COV1611 01-24
ET1

**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.

HC-PHR799 01-24
ET

# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

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

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

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem. This does not include coverage for congenital defects or anomalies.

HC-EXC622 01-24
ET

# Definitions

**Dependent**

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

HC-DFS1723 01-22
ET

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

**CERTIFICATE RIDER –** North Dakota Residents

Rider Eligibility: Each Employee who is located in North Dakota

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

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

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

HC-ETNDRDR

**Important Information**

**Rebates and Other Payments**

Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals covered under your plan and Prescription Drug Products included on the Prescription Drug List. These rebates or remuneration are not obtained on you or your Employer's or plan's behalf or for your benefit.

Cigna, its affiliates and the plan are not obligated to pass these rebates on to you, or apply them to your plan's Deductible if any or take them into account in determining your Copayments and/or Coinsurance. Cigna and its affiliates or designees may also conduct business with various pharmaceutical manufacturers separate and apart from this plan's Medical Pharmaceutical and Prescription Drug Product benefits. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this plan. Cigna and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.

**Coupons, Incentives and Other Communications**

At various times, Cigna or its designee may send mailings to you or your Dependents or to your Physician that communicate a variety of messages, including information about Medical Pharmaceuticals and Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you or your Dependents, at your discretion, to purchase the described Medical Pharmaceutical and Prescription Drug Product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Cigna, its affiliates and the plan are not responsible in any way for any decision you make in connection with any coupon, incentive, or other offer you may receive from a pharmaceutical manufacturer or Physician.

HC-IMP425 01-25
ET

# Eligibility - Effective Date

## Dependent Insurance

**Exception for Newborns**

Any Dependent child born or adopted while you are insured will become insured on the date of his birth or with respect to an adopted child, the date of physical placement by a licensed child placement agency or by the birth parent, if you elect Dependent Insurance no later than 31 days after his birth or placement for adoption. If you do not elect to insure your newborn or adopted 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-ELG238 01-19
ET

## Covered Expenses

- charges made for a single baseline mammogram for women ages 35 to 39, a mammogram annually for women age 40 and older, or more often if recommended by a Physician.
- charges for abortion when a Physician certifies in writing that the pregnancy would endanger the life of the mother, or when the expenses are incurred to treat medical complications due to abortion.
- charges made for surgical and non-surgical care of Temporomandibular Joint Dysfunction (TMJ) and craniomandibular disorders, excluding appliances and orthodontic treatment.
- coverage for mother and her newborn for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of care following a cesarean section. A shorter length of stay is acceptable if the mother consults with her Physician and both agree it is appropriate and in line with the Guidelines for Perinatal Care prepared by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.

**Virtual Care**

**Dedicated Virtual Providers**

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

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

**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.

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

HC-COV1575 01-25
ET

## Exclusions, Expenses Not Covered and General Limitations

- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for a continuous course of dental treatment for an Injury to teeth are covered. Also, facility charges and charges for general anesthesia or deep sedation which cannot be administered in a dental office are covered when Medically Necessary.
- elective abortions.

HC-EXC605 01-25
ET

## Termination of Insurance

**Special Continuation of Medical Insurance**

If your Active Service ends for any reason other than failure to make any required contributions, and if you have been insured for at least three consecutive months under the policy, and if you pay your Employer the required premium, your Medical Insurance will be continued until the earliest of:

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

- the date you become eligible for insurance under another group policy for medical benefits or under Medicare;
- the date the policy cancels.

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

- the date your insurance ceases; or
- with respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent; or becomes eligible for insurance under another group policy for medical benefits or under Medicare.

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

**Notification of Special Continuation**

The Employer will notify in writing any eligible person, within 10 days after the date that person's insurance would otherwise cease, of his right to elect the continuation and; the amount of each monthly payment. The person may elect the continuation by applying in writing and sending the required premium to the Employer within 31 days after the day his insurance would otherwise cease.

If the person elects such continuation, the required premium must be paid to the Employer.

**Conversion Available Following Continuation**

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

HC-TRM56 04-10
V1-ET

# Definitions

**Dependent**

Dependents are:

- any child of yours who is:
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

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

The term child means a child born to you or a child legally adopted by you including that child from the first day of placement by a licensed child placement agency or by the birth parent. It also includes a stepchild and a child born to one of your Dependent children, as long as your grandchild is living with you and primarily supported by you.

HC-DFS1694 01-22
ET

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

**CERTIFICATE RIDER –** Ohio Residents

Rider Eligibility: Each Employee who is located in Ohio

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

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

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

HC-ETOHRDR

# Eligibility - Effective Date

## Dependent Insurance

### Exception for Newborns

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

HC-ELG256 03-19
ET

# Covered Expenses Under the Medical Plan

- charges made for or in connection with:
  - an annual cytologic screening (Pap smear) for detection of cervical cancer;
  - 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 mammographies 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;
  - 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
  - an annual mammogram for women ages 50 through 64. Your provider will indicate whether your mammogram is for preventive or diagnostic purposes.
- charges include screening mammography to detect the presence of breast cancer and charges for supplemental breast cancer screenings to detect the presence of breast cancer in adult women meeting the following:
  - the woman's/individual's screening mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the woman has dense breast tissue.
  - the woman/individual is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the woman's health care provider.
  - services include ultrasounds, MRI, digital breast tomosynthesis and molecular breast imaging.
- 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.

### Maternity

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

  Inpatient care will include:
  - medical services;
  - educational services; and
  - any other services that are consistent with protocols and guidelines developed by national pediatric, obstetric, and

nursing professional organizations for these services (e.g. AAP/ACOG Guidelines).

**Post-discharge Follow-up**

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

  Follow-up services will include:

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

**Virtual Care - Medical**

**Dedicated Virtual Providers/Telemedicine**

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

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

**Virtual Physician Services/Telemedicine**

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

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

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

HC-COV1599 01-25

ET

**Clinical Trials**

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

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

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

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

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

other coverage under the plan for services performed by Participating and non-Participating providers.

- Routine Patient Care means all health care services consistent with the coverage provided in the health benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial and that was not necessitated solely because of the trial.

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

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

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

HC-COV963 ET

# The Schedule

The pharmacy Schedule is amended to indicate the following:

**Oral Chemotherapy Medication**

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

SCHEDPHARM90-ohet

# Prescription Drug Benefits

## Limitations

**Step Therapy**

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

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

**Supply Limits**

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

To be eligible a drug must: (1) Be covered under the plan; (2) Be prescribed for the treatment and management of a chronic disease or condition and be subject to refills; (3) Satisfy all

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

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

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

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

**Specialty Prescription Drug Products**

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

HC-PHR569 01-23 ET

# The Schedule

The pharmacy Schedule is amended to indicate the following:

**Oral Chemotherapy Medication**

Prescription oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered at Network Pharmacies at 100% after deductible, if applicable.

SCHEDPHARM90-ohet1

# Prescription Drug Benefits

## Limitations

### Step Therapy

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

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

**Supply Limits**

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

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

To be eligible a drug must: (1) Be covered under the plan; (2) Be prescribed for the treatment and management of a chronic disease or condition and be subject to refills; (3) Satisfy all relevant prior authorization criteria; (4) Not have any quantity limits, dose optimization criteria, or other requirements that would be violated if synchronized; (5) Not have an special handling or sourcing needs, as determined by the plan that require a single designated Pharmacy to fill or refill the prescription; (6) Be formulated so that the quantity or amount dispensed can be effectively divided in order to achieve synchronization; (7) Not be a schedule II controlled substance, opiate, or benzodiazepine.

A policy or plan shall authorize coverage of a prescription drug subject to medication synchronization when the drug is dispensed in a quantity or amount that is less than a thirty one (31) day supply. Medication synchronization applies only once for each prescription drug subject to medication synchronization for the same insured unless; a) the prescriber changes the dosage or frequency of administration of a prescription drug subject to medication synchronization or; b) the prescriber prescribes a different drug.

Shall permit and apply a prorated daily cost-sharing rate for a supply of a prescription drug subject to medication synchronization that is dispensed at a Network Pharmacy. Requirement does not waive any cost-sharing in its entirety.

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

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

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

**Specialty Prescription Drug Products**

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

HC-PHR576 01-23
ET

## Medical Conversion Privilege

**For You and Your Dependents**

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

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

**Employees Entitled to Convert**

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

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

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

**Dependents Entitled to Convert**

The following Dependents are also Entitled to Convert:

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

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

**Overinsured**

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

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

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

**Converted Policy**

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

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

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

Policyholder will give you, on request, further details of the Converted Policy.

HC-CNV26

HC-CNV27 04-10

V1-ET

# Payment of Benefits

**Recovery of Overpayment on a Provider Claim**

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

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

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

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

HC-POB149 03-19

ET

# Termination of Insurance

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

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

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

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

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

**Special Continuation of Medical Insurance**

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

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

your Medical Insurance will be continued until:

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

whichever occurs first.

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

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

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

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

HC-TRM140 12-18
ET

# Medical Benefits Extension

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

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

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

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

HC-BEX31 04-10
V1-ET

# Definitions

**Dependent**

Dependents are:

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

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

It also includes a stepchild or a child for whom you are the legal guardian.

HC-DFS1690 01-23
ET

**Synchronous, Real Time Communication**

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

HC-DFS1335 03-19
ET

**Teledentistry**

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

HC-DFS1336 03-19

ET

**Telemedicine/Virtual Care**

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

HC-DFS1526 ET

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

**CERTIFICATE RIDER –** Oklahoma Residents

Rider Eligibility: Each Employee who is located in Oklahoma

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 Oklahoma group insurance plans covering insureds located in Oklahoma. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETOKRDR

## The Schedule

Any references to “Chiropractic Care” are hereby changed to read “Manipulative Services”.

SCHEDOK-ETC

## The Schedule

The following note is hereby added to the “Durable Medical Equipment” provision in The Schedule of your medical certificate:

**Note:**

If there are no in-network providers within 15 miles of the patient’s home, out-of-network providers must be reimbursed at the same rate and benefit level as in-network providers.

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### Covered Expenses

- charges for Medically Necessary serological tests for syphilis for pregnant women.
- charges for abortion when a Physician certifies in writing that the pregnancy would endanger the life of the mother.
- charges for bone density tests when ordered by a Physician for a woman age 45 and older who has: an estrogen hormone deficiency; vertebral abnormalities; primary hyperparathyroidism; a history of fragility bone fractures; or who is receiving long-term glucocorticoid; or under treatment for osteoporosis.
- charges made for diagnostic examinations for breast cancer and in connection with mammograms for breast cancer screening for a single low-dose mammogram every five years for women ages 35 through 39 and one annually for women age 40 and over, will not be subject to plan Deductibles, Copayments and Coinsurance.

Diagnostic Examination for Breast Cancer means a Medically Necessary and clinically appropriate examination, as defined by current guidelines and as determined by a clinician who is evaluating the individual for breast cancer, to evaluate the abnormality in the breast that is: seen or suspected from a screening examination for breast cancer, detected by another means of examination, or suspected based on the medical history or family medical history of the individual. This examination may include, but is not limited to, a diagnostic

mammogram which uses x-ray and is designed to evaluate abnormality in a breast, Breast magnetic resonance imaging, diagnostic tool to produce detailed images of the breast, or breast ultrasound which uses high-frequency sound waves to produce detailed images of the breast.

Low Dose Mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast, digital mammography, or breast tomosynthesis. Breast Tomosynthesis means a radiologic mammography procedure involving the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which breast cancer screening diagnoses may be made.

HC-COV1626 01-25
ET

**Transplant Services and Related Specialty Care**

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral. Implantation procedures for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO), ventricular assist device (VAD), and intra-aortic balloon pump (IABP) are also covered.

- All transplant services and related specialty care services, other than cornea transplants, are covered when received at Cigna LifeSOURCE Transplant Network® facilities.
- Transplant services and related specialty care services received at any other facility, including non-Participating Provider facilities and Participating Provider facilities, are covered at the Out-of-Network level.

HC-COV1484 01-24
ET

## Limitations

### Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.

### Step Therapy Exceptions

If your plan is subject to a step therapy program, Cigna will provide, to you and your Provider, access to a clear, convenient and readily accessible process to request a step therapy exception available at www.cigna.com.

A step therapy exception request will be granted if the submitted documentation is completed and supports the statement of the provider that:

- The required prescription drug is contraindicated or will likely cause an adverse reaction or physical/mental harm;
- The drug is expected to be ineffective;
- You have tried the required drugs and use was discontinued due to lack of efficacy or effectiveness, diminished effect or adverse event;
- The drug is not in your best interest;
- You are stable on a prescription drug selected by your provider for the medical condition under consideration while on your current or previous health insurance plan.

You shall have the right to appeal any decision rendered on a request for a step therapy exception. Responses to requests for step therapy exceptions or appeals will be determined within 72 hours of the receipt of request. Your provider can request an urgent exception request or urgent appeal which must be responded to within 24 hours of the receipt of request. Failure to respond within those timeframes results in approval of the exception request or appeal, and Cigna must authorize coverage for the drug.

Step therapy requirements do not apply to covered Prescription Drug Products prescribed for treatment of advanced metastatic cancer when the prescribed Prescription Drug product is FDA-approved and used consistent with best practices for the treatment of advanced metastatic cancer or associated conditions and is supported by peer-reviewed, evidenced-based literature.

**Step Therapy Exception Request for CRF-COPD**

Circumstances requiring an exception to a treatment step therapy protocol:

- Other treatments have shown not to be effective as other available options when prescribed consistent with clinical indications or other peer-review evidence.
- Delay of effective treatment to lead to severe or irreversible consequences and treatment initially required under step therapy is expected to be less effective.
- Other treatments are contraindicated or have caused (or likely to cause) an adverse reaction or physical harm.
- Other treatment is likely to prevent the member from achieving/maintaining reasonable and safe functional ability in job responsibilities or activities of daily life.
- The disease state is classified as life threatening.

Information regarding this process is available at www.cigna.com.

A determination (or request for additional information) must be communicated to your provider within 72 hours of receiving the request.

For urgent requests, determinations must be rendered:

Within 1 business day; or if additional information is required, an insurer must reach out within 1 business day of the request. Once the additional information is received, Cigna must respond as quickly as the condition requires, but no later than 1 business day.

**Supply Limits**

Prescription drug coverage shall provide for synchronization of prescription drug refills on at least one occasion per insured per year, provided all of the following conditions are met:

- The prescription drugs are covered by the plan's clinical coverage policy or have been approved by a formulary exceptions process;
- The prescription drugs are maintenance medications as defined by the plan and have available refill quantities at the time of synchronization;
- The medications are not Schedule II, III or IV controlled substances;
- You or your Dependent meet all utilization management criteria to the prescription drugs at the time of synchronization;
- The prescription drugs are of a formulation that can be safely split into short-fill periods to achieve synchronization;
- The prescription drugs do not have special handling or sourcing needs as determined by the plan that require a single, Designated Pharmacy to fill or refill the prescription; and
- You agree to the synchronization.

When necessary to permit synchronization, the plan shall apply a prorated daily cost-sharing rate to any medication dispensed by a Network Pharmacy. No dispensing fees shall be prorated, and all dispensing fees shall be based on the number of prescriptions filled or refilled.

Synchronization means the coordination of medication refills for a patient taking two or more medications for one or more chronic conditions such that the patient's medications are refilled on the same schedule for a given time period.

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

HC-PHR814 01-25

ET

# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

- abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother.

HC-EXC627 01-25

ET

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

**CERTIFICATE RIDER –** Pennsylvania Residents

Rider Eligibility: Each Employee who is located in Pennsylvania

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

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 Pennsylvania group insurance plans covering insureds located in Pennsylvania. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETPARDR

# The Schedule

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

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

"3 visits; the visit limit does not apply to treatment of diabetes."

SCHEDPA ET

## Covered Expenses

- charges for an annual breast cancer screening. 3-Dimensional screenings are not subject to any member cost-share after applicable Deductible if not eligible for coverage under the Preventive Care benefit as indicated in The Schedule.
- charges for an annual supplemental breast cancer screening when Medically Necessary and clinically appropriate using either standard or abbreviated magnetic resonance imaging (MRI), or ultrasound if MRI is not possible, not subject to member cost-share after applicable Deductible, for a woman who is at an increased risk of breast cancer.
- charges for an annual gynecological exam, including a pelvic exam and a routine pap smear, not subject to any Deductible or dollar limits.
- charges for colorectal cancer screening for:
  - a non-symptomatic covered person age 50 and older includes but is not limited to: an annual fecal occult blood test; a sigmoidoscopy, a screening barium enema or a test consistent with approved medical standards and practices to detect colon cancer, at least once every 5 years; and a colonoscopy at least once every 10 years.
  - a non-symptomatic covered person under age 50 who is at high or increased risk for colorectal cancer according to American Cancer Society guidelines includes but is not limited to colonoscopy or any combination of colorectal cancer screening tests according to American Cancer Society Guidelines.
  - a symptomatic covered person includes a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at frequency determined by the treating Physician.
- charges for childhood immunizations, including the immunizing agents and Medically Necessary booster doses. Immunizations provided in accordance with Advisory Committee on Immunization Practices (ACIP) standards are covered for any insured person under age 21 and are exempt from Deductibles or dollar limits.
- charges for at least 48 hours of inpatient care following a mastectomy. A longer period of time will be covered if the treating Physician determines it is Medically Necessary. Home health care services will also be provided if the treating Physician deems these services Medically Necessary.
- charges for diabetes equipment and medical nutrition therapy related to diabetes management.

**Enteral Nutrition**

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

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

Medically Necessary nutritional support formulas for therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria that are administered under the direction of a Physician are not subject to a Deductible.

HC-COV1511 01-24
ET1

## Covered Expenses

**Breast Reconstruction and Breast Prostheses**

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; postoperative breast prostheses; 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.

**Reconstructive Surgery**

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

HC-COV1384 01-23
ET

## Limitations

For covered prescription eye drops, an early refill will be allowed, up to the total number of refills indicated in the original prescription, if the renewal is requested in these time periods from the later of the original prescription date or the date of the most recent refill:

- for a 30-day supply, between 21 and 30 days.
- for a 60-day supply, between 42 and 60 days.
- for a 90-day supply, between 63 and 90 days.

HC-PHR755 01-24
ET

# Definitions

**Dependent**

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

HC-DFS1675 01-22
ET

**Prescription Drug Product**

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

- certain durable products and supplies that support drug therapy;
- certain diagnostic testing and screening services that support drug therapy;
- certain medication consultation and other medication administration services that support drug therapy; and
- certain digital products, applications, electronic devices, software and cloud-based service solutions used to predict,

detect and monitor health conditions in support of drug therapy.

HC-DFS1977 01-24
ET

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

**CERTIFICATE RIDER –** Rhode Island Residents

Rider Eligibility: Each Employee who is located in Rhode Island

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

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

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

HC-ETRIRDR

# Important Notices

## Rhode Island Mandatory Civil Unions Endorsement For Health Insurance

### Purpose:

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

### Definitions, Terms, Conditions And Provisions

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

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

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

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

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

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

**Caution: Federal Rights May Or May Not Be Available**

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

HC-IMP105 01-12
V1-ET

## Home Health Care Services

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

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

- the required skilled care cannot be obtained in an outpatient facility.
- confinement in a Hospital or Other Health Care Facility is not required.

- the patient’s home is determined by Cigna to be the most medically appropriate place to receive specific services.

Covered services include:

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

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

The following are excluded from coverage:

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

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

HC-COV1136 04-21
ET

## Prescription Drug Benefits

### Exclusions

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

  In the event that Cigna determines that this exclusion applies, then Cigna shall have the right to:

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

reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover.
- charges or payment for arising out of healthcare-related services that violate state or federal law.

HC-PHR815 01-25 ET

# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

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

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

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

HC-EXC628 01-25 ET

# Coordination of Benefits

## Recovery of Excess Benefits

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

Cigna will have discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company,

healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

HC-COB310 04-21 ET

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

**CERTIFICATE RIDER –** South Carolina Residents

Rider Eligibility: Each Employee who is located in South Carolina

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

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

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

HC-ETSCRDR

# Eligibility - Effective Date

## Employee Insurance

### Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 31 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

## Dependent Insurance

### Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 31 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

HC-ELG1 04-10 V8-ET

# The Schedule

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

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

“3 visits; the visit limit does not apply to treatment of diabetes.”

SCHEDSC ET

## Covered Expenses

- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage on oral contraceptives.
- charges made for Medically Necessary care and treatment of cleft lip and palate as well as any condition or illness which is related to or developed as a result of cleft lip and palate. This includes, but is not limited to oral/facial surgery, teeth capping prosthodontics, orthodontics, otolaryngology, and audiological care. If the procedures are also covered by a dental policy, medical benefits can be excluded for prosthodontics, including teeth capping, and orthodontics.
- charges for inpatient care for up to 48 hours after a vaginal delivery and up to 96 hours after a caesarean section for a mother and her newborn, payable as any other inpatient stay. The day of delivery or surgery will not count toward the length of stay. Any length of stay beyond the 48 or 96 hours will be covered if determined Medically Necessary.

This does not prevent a mother and her newborn from being discharged earlier than the 48 or 96 hours if the mother and doctor agree to the earlier discharge.

- charges for hospitalization benefits for at least 48 hours following a mastectomy. A shorter stay is acceptable when ordered by the attending Physician. In the case of an early release, coverage must include at least one home care visit, if ordered by the attending Physician.
- charges for one mammogram for women age 35 to 39; one mammogram every two years for women age 40 to 49; and an annual mammogram for women age 50 and older.
- charges for an annual Pap smear, and additional Pap smears when recommended by a Physician.
- charges made for treatment of Autistic Disorder, Asperger's Syndrome, and Pervasive Developmental Disorder - Not Otherwise Specified, and Applied Behavioral Analysis (ABA) Therapy.

HC-COV1554 01-24 ET

**Breast Reconstruction and Breast Prostheses**

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; postoperative breast prostheses; 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.

**Reconstructive Surgery**

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

HC-COV631 12-17 ET

**Medical Pharmaceuticals**

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

HC-COV1555 01-24 ET

# Prescription Drug Benefits

## Covered Expenses

### Contraceptives

Covered Expenses includes charges for Prescription Drug Products used for contraception.

HC-PHR760 01-24 ET

# Medical Conversion Privilege

### For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by Cigna only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to Cigna within 60 days after the date his insurance ceases. Evidence of good health is not needed.

**Employees Entitled to Convert**

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

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

If you retire you may apply for a Converted Policy within 60 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

**Dependents Entitled to Convert**

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death; (In the case of divorce, the former spouse must make written application and pay the required premium within 60 days after the entry of final decree.)
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

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

**Overinsured**

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

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

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

**Converted Policy**

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

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

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

Policyholder will give you, on request, further details of the Converted Policy.

HC-CNV1 04-10
V3-ET

# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

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

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

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.

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

  The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of the prescribed indication in one of the following: United States Pharmacopoeia Drug Information; American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; or two articles from major peer-reviewed medical literature.

HC-EXC597 01-24
ET

# Medical Benefits Extension

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

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

**Totally Disabled**

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

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

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

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

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

HC-BEX32 04-10
V1-ET

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

**CERTIFICATE RIDER –** Tennessee Residents

Rider Eligibility: Each Employee who is located in Tennessee

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 Tennessee group insurance plans covering insureds located in Tennessee. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETTNRDR

# The Schedule

If you are enrolled in a medical plan other than a Comprehensive medical plan, The Schedule of your medical certificate is amended as follows:

The In-Network Outpatient Therapy Services provision in The Schedule of your medical certificate is updated to indicate it is subject to the same cost-share as any other Primary Care Physician's office visit.

If the Outpatient Therapy Services provision is subject to a maximum, the text "for all therapies combined" is hereby removed.

If the Outpatient Therapy Services provision in The Schedule of your medical certificate includes Chiropractic Care/Self-Referral Chiro, it is hereby covered as a separate benefit and not subject to any separate Chiropractic Care/Self-Referral Chiro maximum. In-Network Chiropractic Care/Self-Referral Chiro will be paid the same as any other Primary Care Physician's office visit.

If you are enrolled in a Comprehensive medical plan, The Schedule of your medical certificate is amended as follows:

The Outpatient Therapy Services provision is subject to the same cost-share as any other Primary Care Physician's office visit.

If the Outpatient Therapy Services provision is subject to a maximum, the text "for all therapies combined" is hereby removed.

If the Outpatient Therapy Services provision in The Schedule of your medical certificate includes Chiropractic Care, it is hereby covered as a separate benefit, not subject to any separate Chiropractic Care maximum and subject to the same cost-share as any other Primary Care Physician's office visit.

SCHEDTN-tnetc

## Covered Expenses

- charges for treatment of conditions or disorders of hearing, speech, voice or language if treatment is received from a licensed audiologist or speech pathologist.
- charges made for or in connection with a drug that has been prescribed for the treatment of a type of condition for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be covered, provided: it is recognized as medically appropriate for the treatment of the specific type of condition for which the drug has been prescribed in any one of the following reference compendia: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; United States Pharmacopeia Drug Information; or the drug is recommended by one review article in a U.S. peer-reviewed national professional journal; it has been otherwise approved by the FDA; its use for the specific type of treatment prescribed has not been contraindicated by the FDA.

HC-COV1668 01-26

ET

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

**CERTIFICATE RIDER –** Texas Residents

Rider Eligibility: Each Employee who is located in Texas

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 Texas group insurance plans covering insureds located in Texas. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETTXRDR

**CIGNA HEALTH AND LIFE INSURANCE COMPANY**
**Home Office: Bloomfield, Connecticut**
**Mailing Address: 900 Cottage Grove Road**
**Hartford, Connecticut 06152**

## Important Information

Texas Department of Insurance Notice – Preferred Provider Plans

You have the right to an adequate network of preferred providers (also known as "network providers").

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
- If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

You have the right, in most cases, to obtain estimates in advance:

- from out-of-network providers of what they will charge for their services; and
- from your insurer of what they will pay for the services.

You may obtain a current directory of preferred providers at the following website: www.cigna.com or by calling 1-888-992-4462 for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

- If you are treated by a provider or Hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

  If the amount you owe to an out-of-network Hospital-based radiologist, anesthesiologist, pathologist, emergency department Physician, or neonatologist is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network Hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.

HC-IMP152 01-15

**CIGNA HEALTH AND**
**LIFE INSURANCE COMPANY**
**Home Office: Bloomfield, Connecticut**
**Mailing Address: 900 Cottage Grove Road**
**Hartford, Connecticut 06152**

## Important Information

Texas Department of Insurance Notice – Exclusive Provider Plans

An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.

You have the right to an adequate network of preferred providers (also known as "network providers").

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

If your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the non-preferred provider's bill so that you only have to pay any applicable coinsurance, copay and deductible amounts.

You may obtain a current directory of preferred providers at the following website: www.cigna.com or by calling 1-888-992-4462 for assistance in finding available preferred providers. If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

HC-IMP157 01-15

**Have a complaint or need help?**

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Cigna

To get information or file a complaint with your insurance company:

Call toll-free: 1-800-997-1654
Online: www.cigna.com
Mail: P.O. Box 188011
Chattanooga, TN 37422

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

**Tiene una queja o necesita ayuda?**

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Cigna

Para obtener información o para presentar una queja ante su compañía de seguros:

Teléfono gratuito: 1-800-997-1654
En línea: www.cigna.com
Dirección postal: P.O. Box 188011
Chattanooga, TN 37422

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

**Notice of Coverage for Acquired Brain Injury**

Your health benefit plan coverage for an acquired brain injury includes the following services:

- cognitive rehabilitation therapy;
- cognitive communication therapy;
- neurocognitive therapy and rehabilitation;
- neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment;
- neurofeedback therapy and remediation;
- post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and
- reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute care treatment or services may be obtained in any facility where such services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

**The following words and terms shall have the following meanings:**

Acquired brain injury -- A neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Cognitive communication therapy -- Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive rehabilitation therapy -- Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Community reintegration services -- Services that facilitate the continuum of care as an affected individual transitions into the community.

Enrollee -- A person covered by a health benefit plan.

Health benefit plan -- As described in the Insurance Code §1352.001 and §1352.002.

Issuer -- Those entities identified in the Insurance Code §1352.001.

Neurobehavioral testing -- An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

Neurobehavioral treatment -- Interventions that focus on behavior and the variables that control behavior.

Neurocognitive rehabilitation -- Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive therapy -- Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback therapy -- Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological testing -- An evaluation of the functions of the nervous system.

Neurophysiological treatment -- Interventions that focus on the functions of the nervous system.

Neuropsychological testing -- The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological treatment -- Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Other similar coverage -- The medical/surgical benefits provided under a health benefit plan. This term recognizes a distinction between medical/surgical benefits, which encompass benefits for physical illnesses or injuries, as opposed to benefits for mental/behavioral health under a health benefit plan.

Outpatient day treatment services -- Structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

Post-acute care treatment services -- Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-acute transition services -- Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Psychophysiological testing -- An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological treatment -- Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Remediation -- The process(es) of restoring or improving a specific function.

Services -- The work of testing, treatment, and providing therapies to an individual with an acquired brain injury.

Therapy -- The scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

**Examinations for Detection of Cervical Cancer**

Benefits are provided for each covered female age 18 and over for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Benefits include at a minimum a conventional Pap smear screening; or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in

combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224 or write us at the address on the back of your ID card.

**Coverage and/or Benefits For Reconstructive Surgery After Mastectomy – Enrollment**

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

- all stages of the reconstruction of the breast on which mastectomy has been performed;
- surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
- prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending Physician.

**Prohibitions:**

We may not:

- offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above;
- condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above;
- reduce or limit the amount paid to the Physician or provider, nor otherwise penalize, or provide a financial incentive to induce the Physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224 or write us at the address on the back of your ID card.

**Coverage and/or Benefits For Reconstructive Surgery After Mastectomy – Annual**

Your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224 or write us at the address on the back of your ID card.

**Coverage for Mastectomy or Lymph Node Dissection**

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

- 48 hours following a mastectomy, and
- 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending Physician determine that a shorter period of inpatient care is appropriate.

**Prohibitions:**

We may not:

- deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours;
- provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours;
- reduce or limit the amount paid to the attending Physician, or otherwise penalize the Physician, because the Physician required a covered person to receive the minimum inpatient hours; or
- provide financial or other incentives to the attending Physician to encourage the Physician to provide care that is less than the minimum hours.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224 or write us at the address on the back of your ID card.

**Coverage for Examinations for Detection of Prostate Cancer**

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

- a physical examination for the detection of prostate cancer; and
- a prostate-specific antigen test for each covered male who is:
  - at least 50 years of age; or

- at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224 or write us at the address on the back of your ID card.

**Coverage for Inpatient Stay Following Birth of a Child**

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery, and
- 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a Hospital or Other Health Care Facility or (b) remain in a Hospital or Other Health Care Facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a Physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

**Prohibitions:**

We may not:

- modify the terms of this coverage based on any covered person requesting less than the minimum coverage required;
- offer the mother financial incentives or other compensation for waiver of the minimum number of hours required;
- refuse to accept a Physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the Physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians;
- reduce payments or reimbursements below the usual and customary rate; or
- penalize a Physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224 or write us at the address on the back of your ID card.

**Coverage for Tests for Detection of Colorectal Cancer**

Benefits are provided, for each person enrolled in the plan who is 45 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include:

- all colorectal cancer examinations, preventative services, and laboratory tests assigned a grade A or B by the U.S. Preventive Services Task Force for average-risk individuals, including services that may be assigned a grade of A or B in the future; and
- an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

Cost-sharing requirements may be imposed if the service or benefits is obtained from an Out -of-Network provider. If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224, or write us at the address on the back of your ID card.

HC-IMP400 01-25
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# The Schedule

The following sentence is added to the “Hospital Emergency Room” section under the “Emergency and Urgent Care Services” section of **The Schedule** shown in your medical certificate:

**Emergency and Urgent Care Services**

Hospital Emergency Room

(including a properly licensed freestanding emergency medical care facility)

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

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

"3 visits; the visit limit does not apply to treatment of diabetes"

SCHEDTX ET

## Covered Expenses

- charges for Emergency Services.
- charges made for an annual low dose mammography screening for women 35 years of age and older. Coverage will also be provided for a diagnostic imaging.
  - Diagnostic imaging means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate: a subjective or objective abnormality detected by a Physician or patient in a breast; an abnormality seen by a Physician on a screening mammogram; an abnormality previously identified by a Physician as probably benign in a breast for which follow-up imaging is recommended by a Physician; or an individual with a personal history of breast cancer or dense breast tissue.
  - Low dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, and screens with an average radiation exposure delivery of less than on rad mid-breast and with two views for each breast, digital imaging or breast tomosynthesis.
  - Breast tomosynthesis means a radiologic mammography procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which applicable breast cancer screening diagnoses may be determined.
- charges for men's family planning, counseling, testing and sterilization (e.g. vasectomies), excluding reversals.
- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage or oral contraceptives.
- charges made for reconstructive surgery of craniofacial abnormalities for a child who is younger than 18 years of age to improve the function of, or to attempt to create a normal appearance for an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease.
- charges made for an acquired brain injury including the following when they are Medically Necessary: cognitive rehabilitation therapy; cognitive communication therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment; neurofeedback therapy and remediation; post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and reasonable expenses related to periodic re-evaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.
- charges made for an annual medically recognized diagnostic examination for the early detection of cervical and ovarian cancer for each covered female age 18 and over. Such coverage shall include at a minimum: a CA 125 blood test and a conventional pap smear screening; or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus; and any other test or screening approved by the FDA for detection of ovarian cancer.
- charges for a screening test for hearing loss from birth through the date the child is 30 days old, and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old without application of a Deductible.
- charges for or in connection with a medically recognized screening exam for the detection of colorectal cancer for each insured who is at least 45 years of age and at normal risk for developing colon cancer. Coverage will include: all colorectal cancer examinations, preventive services, and laboratory tests assigned a grade A or B by the U.S. Preventive Services Task Force for average-risk individuals, including services that may be assigned a grade of A or B in the future; and an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.
- charges for screening medical procedures for up to $200 for one of the following non-invasive screening tests for

atherosclerosis and abnormal artery structure and function every five (5) years for covered individuals who meet certain criteria:

- computed tomography (CT) scanning measuring artery calcification; or
- ultrasonography measuring carotid intima-media thickness and plaque.

To qualify for coverage covered individuals must be:

- a male older than 45 years of age and younger than 76 years of age or a female older than 55 years of age and younger than 76 years of age; and
- diabetic or have a high risk of developing coronary heart disease based on a score derived using the Framingham Heart Study prediction algorithm that is intermediate or higher.

The screening must be performed by a laboratory that is certified by a national organization recognized by the Commissioner of Insurance (by rule).

- charges made for all generally recognized services prescribed in relation to Autism Spectrum Disorder for Dependent children. Such coverage must include a screening at the ages of 18 and 24 months. Such coverage must be prescribed by a Physician in a treatment plan and shall include evaluation and assessment services; applied behavior analysis; behavior training and behavior management; speech therapy; occupational therapy; physical therapy; or medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder. The individual prescribing such treatment must be a health care practitioner:
  - who is licensed, certified, or registered by an appropriate agency of this state;
  - whose professional credential is recognized and accepted by an appropriate agency of the United States;
  - who is certified as a provider under the TRICARE military health system; or
  - an individual acting under the supervision of a health care practitioner described above.

  Autism Spectrum Disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder--Not Otherwise Specified. Neurobiological disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors.
- charges for inpatient care for a mother and her newborn child for 48 hours following an uncomplicated vaginal delivery, or for 96 hours following an uncomplicated cesarean delivery in a health care facility. Any decision to shorten the stay must be made by the Physician in consultation with the mother. If the mother is discharged prior to the 48 or 96 hours described above, a postdelivery home care visit will be covered. Postdelivery home care services include parent education; assistance and training in breast feeding and bottle feeding; and the performance of any necessary and appropriate clinical tests. If Medical Necessity requires the mother and/or newborn to remain confined for longer than 48 hours, the additional confinement will be covered.
- charges for administration of newborn screening tests, including for the cost of a newborn screening test kit as dictated by the Department of State Health Services.
- charges for Medically Necessary diagnostic, treatment and surgical procedures for conditions effecting temporomandibular joint and craniomandibular disorders which are a result of: an accident; trauma; a congenital defect; a developmental defect; or a pathology.
- charges made for surgical and nonsurgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- charges made for or in connection with annual diagnostic examinations for the detection of prostate cancer, regardless of Medical Necessity. Benefits include a physical exam and a prostate-specific antigen (PSA) test for a man who is at least 50 years of age or at least 40 years of age with a family history of prostate cancer, or another prostate cancer risk factor.
- charges for a minimum of 48 hours of inpatient care following a mastectomy and a minimum 24 hours following a lymph node dissection for the treatment of breast cancer. A shorter period of inpatient care may be deemed acceptable if the insured consults with the Physician and both agree it is appropriate.
- charges for immunizations for children from birth through age 5. These immunizations will include: diphtheria; Haemophilus influenzae type B; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella (chicken pox); rotavirus; and any other children's immunizations required by the State Board of Health. A Deductible, Copayment, or Coinsurance is not required for immunizations.

- charges for a medically acceptable bone mass measurement to detect low bone mass and to determine the risk of osteoporosis and fractures associated with osteoporosis.
- charges for complications of pregnancy.
- charges made by a Hospital or ambulatory surgical facility for anesthesia and facility charges for dental care for a covered person who is unable to undergo such treatment in an office setting or under local anesthesia due to a documented physical, mental or medical reason as determined by their Physician or by the dentist providing the dental care.
- charges for biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of an individual's disease to guide treatment when supported by medical and scientific evidence.
- charges for fertility preservation services for individuals receiving Medically Necessary treatment for cancer. These services include: collection and preservation of sperm, unfertilized oocytes, and ovarian tissue, but does not include storage of such unfertilized genetic materials. Treatment for cancer includes surgery, chemotherapy, or radiation that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established may cause impaired fertility.

**Hearing Aids and Cochlear Implants for Children**

Coverage will be provided for hearing aids and cochlear implants for children 18 years and younger so long as they are Medically Necessary. Such coverage shall include:

- fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of the hearing aids;
- treatment related to hearing aids/cochlear implants, including coverage for habilitation and rehabilitation; and
- external speech processor and controller with necessary replacements every three years (for cochlear implants).

Coverage for hearing aids will be limited to one hearing aid in each ear every three years. Coverage for cochlear implants will be limited to one cochlear implant in each ear with internal replacement (medically or audiologically necessary).

**Diabetes**

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:

Diabetes Equipment and Training:

- blood glucose monitors, including those designed to be used by the legally blind.
- podiatric appliances, including up to two pair of therapeutic footwear per year, for the prevention of complications associated with diabetes.

If determined as Medically Necessary by a treating practitioner/Physician, new or improved treatment and monitoring equipment (approved by the FDA) shall be covered.

The training program for diabetes self-management shall be recognized by the American Diabetes Association and shall be performed by a certified diabetes educator (CDE), a multidisciplinary team coordinated by a CDE (e.g., a dietician, Nurse educator, pharmacist, social worker), or Other Health Professional (e.g., Physician, physician assistant, registered Nurse, registered dietician, pharmacist) determined by his or her licensing board to have recent experience in diabetes clinical and educational issues. All individuals providing training must be certified, licensed or registered to provide appropriate health care services in Texas.

Self-management training shall include the development of an individual plan, created in collaboration with the member that addresses:

- nutrition and weight evaluation;
- medications;
- an exercise regimen;
- glucose and lipid control;
- high risk behaviors;
- frequency of hypoglycemia and hyperglycemia;
- compliance with applicable aspects of self-care;
- follow-up on referrals;
- psychological adjustment;
- general knowledge of diabetes;
- self-management skills;
- referral for a funduscopic eye exam.

This training shall be provided/covered upon the initial diagnosis of diabetes or, the written order of the practitioner/Physician when a change in symptoms or conditions warrant a change in the self-management regime or, the written order of a practitioner/Physician that periodic or episodic continuing education is needed.

**Virtual Physician Services**

Includes charges for a “telemedicine medical service”, a “telehealth service” or a “teledentistry dental service” 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.

“Telemedicine medical service” is defined as a health care service delivered by a physician licensed in Texas or provided by a health professional acting under physician supervision and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician using telecommunications or information technology.

“Telehealth service” is defined as a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

"Teledentistry dental service" means a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist’s or health professional’s license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

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

**Enteral Nutrition**

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

Coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism (e.g. disorders of amino acid or organic acid metabolism) including Medically Necessary amino acid based elemental formulas and the services associated with administration of the formulas when prescribed by the treating Physician, regardless of the formula delivery method, that are used for the diagnosis and treatment of: immunoglobulin E and non immunoglobulin E mediated allergies to multiple food proteins; severe food protein-induced enterocolitis syndrome; eosinophilic disorders, as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface functional length, and motility of the gastrointestinal tracts, phenylketonuria (PKU) or an inheritable disease.

HC-COV1682 01-26

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**Mental Health and Substance Use Disorder Services**

**Mental Health Residential Treatment Services** are services provided by a Hospital or Mental Health Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for the evaluation and treatment of a subacute Mental Health Disorder.

**Mental Health Residential Treatment Center or Crisis Stabilization Unit** means an institution which specializes in the treatment of psychological and social disturbances that are the result of a Mental Health Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a Mental Health Residential Treatment Center or Crisis Stabilization Unit. Coverage for necessary care and treatment in a Mental Health Residential Treatment Center or Crisis Stabilization Unit will be provided as if the care and treatment were provided in a Hospital.

**Mental Health Residential Treatment Center for Children and Adolescents** means a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

**Psychiatric Day Treatment Facility** means a Mental Health Residential Treatment Center that is accredited by the Program for Psychiatric Facilities (or its successor) of the Joint Commission on Accreditation of Hospitals; provides treatment of acute mental and nervous disorders, in a structured psychiatric program utilizing individualized treatment plans, for no more than 12 hours in any 24 hour period; and is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

HC-COV1536 01-25 ET

**External Prosthetic Appliances and Devices**

**Prostheses/Prosthetic Appliances and Devices**

Prostheses/prosthetic appliances and devices are defined as artificial devices designed to replace, wholly or partly, an arm or leg. Prostheses/prosthetic appliances and devices include, but are not limited to:

- limb prostheses;
- terminal devices such as hands or hooks;
- speech prostheses; and
- facial prostheses.

**Orthoses and Orthotic Devices**

Orthoses and orthotic devices are defined as customer fitted or custom fabricated medical devices that are applied to a part of the human body to correct a deformity, improve function or relieve symptoms of a disease. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers except when ordered by a Physician for the treatment of diabetes;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

**Braces**

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

**Splints**

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- repair or replacement due to regular wear. Repair or replacement for damage due to abuse or misuse by the person will not be covered.
- replacement required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

- replacement due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited as follows:

- no more than once every 24 months for persons 19 years of age and older; and
- no more than once every 12 months for persons 18 years of age and under.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements for external prosthetic devices;
- microprocessor controlled prostheses and orthoses; and
- myoelectric prostheses and orthoses.

HC-COV1683 01-26
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**Breast Reconstruction and Breast Prostheses**

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; postoperative breast prostheses; 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. Such coverage shall be provided in a manner determined to be appropriate in consultation with the Physician and the insured.

**Reconstructive Surgery**

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.

HC-COV662 12-17
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**Advanced Cellular Therapy**

Advanced cellular therapy products and their administration received from a provider that is not contracted with Cigna for the specific advanced cellular therapy product and related services are covered at the Out-of-Network benefit level when prior authorized.

HC-COV1656 01-26
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## The Schedule

The provision "Coinsurance" shown in the Pharmacy Schedule is hereby replaced with the following:

**Coinsurance**

The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product dispensed by a Network Pharmacy, and it means the percentage of the benchmark price used by Cigna for a covered Prescription Drug Product dispensed by a non-Network Pharmacy, that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.

SCHEDPHARM90-txet1

## The Schedule

The provision "Oral Chemotherapy Medication" shown in the Pharmacy Schedule is hereby replaced with the following:

**Oral Chemotherapy Medication**

Prescription oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered at participating pharmacies at 100% after deductible, if any, and if applicable at non-participating pharmacies, on a basis no less favorable than the out of network medical cost share for injectable/IV chemotherapy.

SCHEDPHARM90-txet2

# The Schedule

The pharmacy schedule is amended to add the following:

**Prescription Insulin Drugs**

The cost share for each covered prescription insulin drug for you and your Dependents shall not exceed $25 for each 30 day supply ($50 for each 60 day supply or $75 for each 90 day supply) regardless of the amount or type of insulin needed to fill each prescription.

SCHEDPHARM90-txet

# The Schedule

The following supersedes any similar provisions under "Patient Assurance Program" in the Pharmacy Schedule:

Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program may count toward your Deductible, if any, and counts toward your Out-of-Pocket Maximum.

Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program may count toward your Deductible, if any, and counts toward your Out-of-Pocket Maximum.

SCHEDPHARM90-txet3

# Prescription Drug Benefits

## Exclusions

- 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. Coverage does include formulas necessary for the treatment of phenylketonuria (PKU) or other inheritable diseases and medications or supplements used to address symptoms of autism spectrum disorder.

HC-PHR838 01-26

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# Prescription Drug Benefits

## Covered Expenses

### Prescription Drug List Management

Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. Determination of inclusion of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and decides whether utilization management requirements or other coverage conditions are based on a number of factors which may include clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

Cigna shall offer to each enrollee at the then-current benefit level and until the enrollee's plan renewal date any Prescription Drug Product that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the Prescription Drug Product has been removed from the Prescription Drug List. Cigna may, however, move a Prescription Drug Product to a lower cost-share tier at any time during the plan year.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy (ies) for coverage, or try another covered Prescription Drug Product(s). Please access the Prescription Drug List through the website shown on your ID card or call member services at the

telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

Cigna shall limit changes to the Prescription Drug List that negatively impacts enrollees to the plan's renewal date. Changes to the Prescription Drug List that negatively impact enrollees include removing a Prescription Drug Product from the Prescription Drug List, moving a Prescription Drug Product to a higher cost-share tier or adding a prior authorization, step therapy or quantity limit requirement to the Prescription Drug Product. Cigna may, however, add Prescription Drug Products to the Prescription Drug List, move Prescription Drug Products to a lower cost-share tier or remove any prior authorization or other utilization management requirements from a Prescription Drug Product during the plan year. You will receive at least sixty (60) days notice of any Prescription Drug List change for which Cigna is required to provide notice to enrollees.

HC-PHR638 01-23
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# Prescription Drug Benefits

## Limitations

### Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors. Your Physician may also request a renewal of a prior authorization at least 60 days before it expires. If at all possible, Cigna will review and provide a determination before the existing authorization expires, if the request was received before the expiration.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the diagnosis and the Prescription Drug Product. 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 Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan orally or by submitting a written request stating why the Prescription Drug Product should be covered.

### Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You or your prescribing Physician may request an exception to a step therapy protocol applicable to a Prescription Drug Product otherwise covered by the plan. The exception request must document why your Physician believes that the preferred Prescription Drug Product alternative(s) are not clinically appropriate for you to use in treatment. Provided you or your Physician submit sufficient information to Cigna with the exception request, Cigna will respond to the exception request within 72 hours of

receipt of the request. If your Physician also expresses a reasonable belief that you require the Prescription Drug Product on an emergent basis, then Cigna will respond to the exception request within 24 hours of receipt. Cigna will assess the documentation provided by your Physician against the terms of the applicable exception criteria, which will be made available to the member or prescriber upon request. If Cigna denies the exception request, it will be considered an "adverse determination," as defined by TIC §1369.0546, and you may appeal the determination. 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. These requirements do not apply to prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions.

**Supply Limits**

Prescription drug coverage shall provide for synchronization of prescription drug refills on at least one occasion per insured per year, provided all of the following conditions are met:

- the prescription drugs are covered by the plan's clinical coverage policy or have been approved by a formulary exceptions process;
- the prescription drugs are maintenance medications as defined by the plan and have available refill quantities at the time of synchronization;
- the medications are not Schedule II, III or IV controlled substances;
- you or your Dependent meet all utilization management criteria to the prescription drugs at the time of synchronization;
- the prescription drugs are of a formulation that can be safely split into short-fill periods to achieve synchronization;
- the prescription drugs do not have special handling or sourcing needs as determined by the plan that require a single, Designated Pharmacy to fill or refill the prescription; and
- you agree to the synchronization.

When necessary to permit synchronization, the plan shall apply a prorated daily cost-sharing rate to any medication dispensed by a Network Pharmacy. No dispensing fees shall be prorated, and all dispensing fees shall be based on the number of prescriptions filled or refilled.

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

**Prescription Eye Drops**

Coverage for a refill for prescription eye drops shall be provided if the:

- refill is requested no earlier than the 21st day after a 30 day supply is dispensed, the 42nd day after a 60 day supply is dispensed or the 63rd day after a 90 day supply is dispensed;
- prescribing Physician indicates on the original prescription that additional quantities are needed;
- refill requested does not exceed the number of additional quantities needed;
- refill is dispensed within the prescribed dosage period; and
- prescription eye drops are a covered benefit under the plan.

HC-PHR752 01-25
ET

# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

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

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

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

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician relies on the coverage policies maintained by Cigna or the Review Organization. Coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines and is recognized for the treatment of prescribed indication in The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information or supported by articles in accepted, peer-reviewed medical literature.

- the following services are excluded from coverage regardless of clinical indications except as may be covered under the “Reconstructive Surgery” benefit: macromastia surgery or gynecomastia surgery; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral and cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- hearing aids for individuals age 19 and older, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). This does not include an external speech processor and controller with necessary replacements every three years (for cochlear implants) for individuals 18 years and younger. A hearing aid is any device that amplifies sound.
- health and beauty aids, cosmetics and dietary supplements. This does not include formulas necessary for the treatment of phenylketonuria (PKU) or other inheritable diseases and medications or supplements used to address symptoms of autism spectrum disorder.

HC-EXC648 01-26 ET

## Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent; (hereinafter individually and collectively referred to as a "Participant,") for which a party may be responsible as a result of having caused or contributed to an Injury or Sickness except for expenses relating to other benefits plans that provide insurance coverage for the Participant (excluding Part B of Medicare).
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

**Subrogation/Right of Reimbursement**

If a Participant incurs a Covered Expense for which, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent proceeds do not exceed the “Subrogation Limit Amount”, which is defined as the lesser of:
- one half of the Participant’s gross recovery from such party, less (as applicable) (i) fees and pro rata shares of expenses incurred in connection with the recovery action to be paid to the Participant’s attorneys pursuant to an agreement between the plan and those attorneys, (ii) in the absence of an agreement, any amounts awarded by a court to the Participant’s attorneys from the plan’s total gross recovery from such party that constitute reasonable fees for the recovery of proceeds for the plan (not to exceed one-third of the plan’s recovery amount) or (iii) in the absence of an agreement, amounts awarded and apportioned by a court to the Participant’s attorneys and the plan’s attorneys out of any subrogation recovery (not to exceed one-third of the plan’s recovery amount) (the foregoing items (i)-(iii) referred to hereinafter as (the “Recovery Fees”)) or

- the total cost of any benefits paid, provided or assumed under the plan as a direct result of the tortious conduct of such party, less the Recovery Fees (as applicable).
- A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent the proceeds of any recovery do not exceed the Subrogation Limit Amount.

**Lien of the Plan**

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan for any recovery amounts obtained by or on behalf of the Participant, not to exceed the Subrogation Limit Amount, against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided that such lien and assignment shall not apply to (a) reasonable fees and pro rata shares of expenses incurred in connection with the recovery action to be paid to the Participant's attorneys pursuant to an agreement between the plan and those attorneys or (b) amounts awarded by a court to the Participant's attorneys that constitute reasonable fees for the recovery of proceeds for the plan (not to exceed one-third of the plan's recovery amount);
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

**Additional Terms**

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan, except for (a) reasonable fees and pro rata shares of expenses incurred in connection with the recovery action to be paid to the Participant's attorneys pursuant to an agreement between the plan and those attorneys or (b) amounts awarded by a court to the Participant's attorneys that constitute reasonable fees for the recovery of proceeds for the plan (not to exceed one-third of the plan's recovery amount). This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not

limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

- Participants must assist the plan in pursing any subrogation or recovery rights by providing requested information.

HC-SUB84 10-16

# Payment of Benefits

### Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

HC-POB208 01-26 ET

## Termination of Insurance

### Special Continuation of Medical Insurance

If Medical Insurance for you or your Dependent would otherwise cease for any reason except due to involuntary termination for cause or due to discontinuance in entirety of the policy or an insured class, coverage may be continued if:

- the person was covered by this policy and/or a prior policy for the three months immediately prior to the date coverage would otherwise cease, and
- the person elects continuation coverage and pays the first monthly premium within 60 days of the later of either the date coverage would otherwise cease or the date required notice is provided.

Coverage will continue until the earliest of the following:

- 6 months after continuation coverage is elected for plans with COBRA and 9 months after continuation coverage is elected for those without;
- the end of the period for which premium is paid;
- the date the policy is discontinued and not replaced;
- the date the person becomes eligible for Medicare; and
- the date the person becomes insured under another similar policy or becomes eligible for coverage under a group plan or a state or federal plan.

### Texas – Special Continuation of Dependent Medical Insurance

If your Dependent's Medical Insurance would otherwise cease because of your death or retirement, or because of divorce or annulment, his insurance will be continued upon payment of required premium, if: he has been insured under the policy, or a previous policy sponsored by your Employer, for at least one year prior to the date the insurance would cease; or he is a Dependent child less than one year old. The insurance will be continued until the earliest of:

- three years from the date the insurance would otherwise have ceased;
- the last day for which the required premium has been paid;
- with respect to any one Dependent, the earlier of the dates that Dependent: becomes eligible for similar group coverage; or no longer qualifies as a Dependent for any reason other than your death or retirement or divorce or annulment; or
- the date the policy cancels.

If, on the day before the Effective Date of the policy, medical insurance was being continued for a Dependent under a group medical policy: sponsored by your Employer; and replaced by the policy, his insurance will be continued for the remaining portion of his period of continuation under the policy, as set forth above.

Your Dependent must provide your Employer with written notice of retirement, death, divorce or annulment within 15 days of such event. Your Employer will, upon receiving notice of the death, retirement, divorce or annulment, notify your Dependent of his right to elect continuation as set forth above. Your Dependent may elect in writing such continuation within 60 days after the date the insurance would otherwise cease, by paying the required premium to your Employer.

HC-TRM27 04-10 V1-ET

# Definitions

### Dependent

Dependents are:

- any child of yours who is
    - less than 26 years old.

- 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan.

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

The term child means a child born to you; a child legally adopted by you; the child for whom you are the legal guardian; the child who is the subject of a lawsuit for adoption by you; the child who is supported pursuant to a court order imposed on you (including a qualified medical child support order) or your grandchild who is your Dependent for federal income tax purposes at the time of application.

HC-DFS1679 01-22 ET

**Emergency Medical Condition**

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting 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; serious dysfunction of any bodily organ or part; or serious disfigurement.

HC-DFS1842 01-23 ET

**Prescription Drug Product**

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

- Certain durable products and supplies that support drug therapy;
- Certain diagnostic testing and screening services that support drug therapy;
- Certain medication consultation and other medication administration services that support drug therapy;
- Certain digital products, applications, electronic devices, software and cloud-based service solutions used to predict, detect and monitor health conditions in support of drug therapy.
- The following diabetic supplies:
  - Test strips specified for use with a corresponding glucose monitor;
  - Lancets and lancet devices;
  - Visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
  - Insulin and insulin analog preparations;
  - Injection aids, including devices used to assist with insulin injection and needleless systems;
  - Insulin syringes;
  - Biohazard disposal containers;
  - Insulin pumps, both external and implantable, and associated appurtenances which include insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin, and other required disposable supplies;
  - Repairs and necessary maintenance of insulin pumps (not otherwise provided under warranty) and rental fees for pumps during the repair and maintenance. This shall not exceed the purchase price of a similar replacement pump;
  - Prescription and non-prescription medications for controlling blood sugar level;
  - Glucagon emergency kits.

HC-DFS1840 01-23 ET

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

**CERTIFICATE RIDER –** Vermont Residents

Rider Eligibility: Each Employee who is located in Vermont

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 Vermont group insurance plans covering insureds located in Vermont. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETVTRDR

# Important Notices

### Vermont Mandatory Civil Unions Endorsement for Health Insurance

**Purpose:**

Vermont 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 Vermont 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 Vermont 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 Vermont 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 Vermont law.

“Dependent” means a spouse, party to a civil union established according to Vermont 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 Vermont 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 Vermont law.

**Caution: Federal Rights May or May Not Be Available**

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

Retirement Income Security Act of 1974 known as "ERISA," controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

HC-IMP217 05-17 ET

**Our Commitment to Quality**

One of our goals is to work with network doctors to give you access to quality care and programs. The Cigna HealthCare Quality Management Program is based on industry standards and objective measures. These help us evaluate the quality of care and services received by our members. The Program helps us focus our improvement efforts. The Program allows for input from our members and providers. This is done through regular analysis of certain items. The findings are reported to quality committees. They help us target areas in need of improvement and monitor change. These items are:

- credentialing process for qualified doctors;
- ongoing assessment of clinical activities and services provided to our members;
- Utilization Management activities and programs for our members;
- program dedicated to communicating customer rights and responsibilities.

Our providers and members serve on local health plan Quality Committees. If you wish to be on the committee, call 1-800-531-4584, ext. 26867133. Or write to us at the address on your ID card.

**Program Results**

**Measuring Success with HEDIS® and CAHPS®**

We evaluate our health plan by using the Healthcare Effectiveness Data and Information Set (HEDIS®)* which measures success in providing preventive health care benefits, and the Consumer Assessment of Healthcare Providers Systems (CAHPS®)** survey tool which measures member satisfaction. We look for opportunities for improvement in the next year. Here are the results from the Vermont 2010 HEDIS® measurement and CAHPS® survey:

| **2011 HEDIS Rates (2010 Data Reported in 2011)** **Depicts rates among Cigna customers in Vermont for receiving preventive healthcare services** | **GPPO[1]** | **PPO[2]** |
|---|---|---|
| Breast Cancer Screening | 79.06% | 72.61% Δ |
| Colorectal Cancer Screening | 81.25% | 50.50% Δ |
| Use of Appropriate Medications for People with Asthma | 94.55% | 91.28% |
| Cholesterol Screening for People with Cardiovascular Conditions | 91.06% | 69.56% Δ |
| HbA1c[3] Screening for People with Diabetes | 96.84% | 83.70% Δ |
| **2011 CAHPS Rates (2010 Data Reported in 2011)** **Depicts customer satisfaction with Cigna in Vermont** | **GPPO** | **PPO** |
| Claims Processing | 91.06% | 87.62% |
| Getting Care Quickly | 92.83% | 89.83% |

| Getting Needed Care | 90.42% | 86.83% |
|---|---|---|
| Doctor's Communication | 96.33% | 94.42% |

Δ This result is from claims data only. Medical record review is not conducted on PPO products.

* HEDIS® is a registered trademark of the National Committee for Quality Assurance.

** CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

[1] "GPPO" means a Preferred Provider Organization product that has a "gatekeeper" feature.

[2] "PPO" means a Preferred Provider Organization product with no "gatekeeper" feature.

[3] "HbA1c" means a blood test that measures average blood sugar levels over the last two to three months.

To learn more about our quality management program or to request a report on our progress in meeting our goals, call 1-800-531-4584, ext. 26867133.

**Resources**

Cigna Healthcare is committed to giving you access to the latest information about our programs, as well as details about key guidelines and procedures. Log on to www.mycigna.com and go to the My Health page to view:

- Cost and Quality Resources, including tools that provide patient safety-related information.
- Health Management Resources such as a health risk assessment tool, on-line coaching programs and A-Z resource topics.
- Condition and Wellness Resources such as weight and nutrition, tobacco cessation and fitness.
- Preventive Health Guidelines/Recommendations.
- On-line Provider Directory.

**Your Role**

Cigna HealthCare values your input and suggestions to improve care to our members. Your participation in plan surveys gives us feedback on plan performance and policy developments.

You have the opportunity to provide input on our policies, serve on our health plan quality committee, and volunteer to participate in focus groups and surveys. Should you wish to provide feedback to the Quality Management Department or to receive more information about the Cigna Healthcare Quality Management Program, the annual program evaluation or chronic care or preventive health measures, please call 800-531-4584, ext. 26867133.

HC-IMP217 05-17
ET1

**Specialist Physician Serving as Primary Care Physician for a Life-Threatening, Degenerative or Disabling Condition**

In Vermont, a member may, upon Cigna approval, use a Specialist as their PCP for a life-threatening, degenerative or disabling condition. The request must include a signed statement from the member requesting the Specialist to serve as the member's PCP and certification from the Specialist of the medical need to serve as the member's PCP.

Upon receipt of this documentation:

- A Cigna Medical Director validates the medical necessity of the request.
- A decision is made within 10 business days or less from receipt of the request.
  - If approved, Cigna will reach out for a signed statement from the Specialist accepting responsibility to serve as the member's PCP, coordinate member care needs and accept the PCP contracted reimbursement rate for primary care services.
  - If the Cigna Medical Director denies the request for a Specialist to serve as the member's PCP, the denial notification includes the reason(s) for denial, appeal rights and confirmation that the determination was made by a Cigna Medical Director.

- The member will be notified in writing within 21 to 30 business days of the decision.

Mailing Address:
Cigna HealthCare
4100 International Pkwy
Suite 1010
Carrollton, TX 75007

HC-IMP217 05-17
ET2

# The Schedule

Any deductible or coinsurance applicable to annual routine or diagnostic mammograms does not apply.

SCHED-VTET

## Certification Requirements

The following provisions regarding how to request PAC apply if your medical certificate includes provisions for Pre-Admission Certification/Continued Stay Review:

**Pre-Admission Certification/Continued Stay Review for Hospital Confinement**

To request PAC, or to obtain information on how to request PAC, you or your Dependent should call the toll-free number on the back of your ID card. For a non-emergency admission, the request should be at least four working days (Monday through Friday) prior to the schedule admission. If you are unable to call four days in advance, you should call as soon as you can. During your call, as for precertification, give us your ID number, and give us the facts regarding your Hospital stay.

The following provision regarding requesting an expedited review of a service requiring prior authorization or precertification applies if your medical certificate includes provisions for Pre-Admission Certification/Continued Stay Review for Hospital Confinement:

You or your Dependent may request an expedited review of a service requiring prior authorization or precertification, as described in the “Preservice Medical Necessity Determinations” provision of this certificate.

The following provision regarding requesting an expedited review of a service requiring prior authorization or precertification applies if your medical certificate includes provisions for Outpatient Certification Requirements:

**Outpatient Certification Requirements**

You or your Dependent may request an expedited review of a service requiring prior authorization or precertification, as described in the “Preservice Medical Necessity Determinations” provision of this certificate.

HC-PAC1 11-14
V17-ET

## Clinical Trials

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

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

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

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

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH).
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Health Care Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).
  - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
- any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if 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);
  - conducted under the auspices of a peer-reviewed protocol that has been approved by the FDA in the form of an investigational new drug application or exemption; 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.

Cancer trials performed by the following facilities will also be covered:

- the Vermont Cancer Center at Fletcher Allen Health Care, the Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center, and a Vermont hospital and its affiliated, qualified Vermont cancer care provides administering approved cancer clinical trials.
- 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 unless the cancer care provider determines this would not be in the best interest of the patient.

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.

HC-COV1132 01-21 ET

# Exclusions, Expenses Not Covered and General Limitations

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

  "Experimental or investigational services" means health care items or services that are:

  - not generally accepted by informed health care providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed, or are;
  - not proven by medical or scientific evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.

HC-EXC589 01-25 ET1

# Termination of Insurance

## Employees

### Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness for at least 12 months. However, your insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels your insurance.

HC-TRM201 03-21 ET

# Medical Benefits Extension Upon Policy Cancellation

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

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

### Totally Disabled

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

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

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

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

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-BEX12 04-10
V1-ET

# Definitions

### Emergency Medical Condition

Emergency medical condition means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- placing the member's physical or mental health in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

HC-DFS446 11-10
V1-ET

### Emergency Services

Emergency Services means health care items and services furnished or required to evaluate and treat an Emergency Medical Condition.

It is Cigna's responsibility, to:

- respond to, defend against and resolve any request, or claim, by a non-Participating Provider of Emergency Services for payment exceeding the amount it was paid or reimbursed by Cigna; and
- serve as the point of contact for you, if you receive any such request or claim by a non-Participating Provider. To obtain more information, you should call the toll-free number shown on the back of your ID card, or call us at our Customer Service/Member Services number at 1-800-351-8513.

HC-DFS393 11-10
V1-ET

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

**CERTIFICATE RIDER –** Virginia Residents

Rider Eligibility: Each Employee who is located in Virginia

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

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

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

# How To File Your Claim

### Payment of Claim

All benefits payable under the Policy are payable within 40 days of receipt of proof of loss. All or any portion of any benefits may be paid to the health care services provider.

# Eligibility - Effective Date

**Exception to Late Entrant Definition**

A person will not be considered a Late Entrant when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to other available coverage; Employer contributions toward the other coverage have been terminated; he no longer qualifies in an eligible class for prior coverage; or if such prior coverage was continuation coverage and the continuation period has been exhausted; and he enrolls for this coverage within 30 days after losing or exhausting prior coverage; or if he is a Dependent spouse or minor child enrolled due to a court order within 31 days after the order is issued.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption or foster care, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective, on the date of marriage, birth, adoption, or placement for adoption or foster care.

**Covered Expenses**

**Gender Affirmation**

Charges for services related to gender affirmation, including gender reassignment surgery. Coverage includes:

- behavioral counseling, outpatient psychotherapy and mental health services for gender dysphoria and associated co-morbid psychiatric diagnosis;
- hormone therapy including continuous hormone replacement therapy;
- genital reconstructive surgical procedures;
- chest reconstructive surgical procedures;
- outpatient laboratory testing to monitor continuous hormone therapy.

# Prescription Drug Benefits

## Limitations

**Step Therapy**

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.

If your treating health care provider submits a request for a step therapy exception determination, the request must state the circumstance that qualifies for a step therapy exception.

We will respond to the exception request with our decision within three (3) business days of receipt of the exception request.

In cases where emergency circumstances exist, we will respond with our decision within 24 hours of receipt of an exception request.

If we grant an exception request, we will authorize coverage for the Prescription Drug Product.

You may request an appeal of any step therapy exception denial by following the appeals process.

## Continuation

**Reinstatement of Medical Insurance**

If your Medical Insurance ceases because of active duty in: the United States Armed Forces; the Reserves of the United States Armed Forces; or the National Guard, the insurance for you and your Dependents will be reinstated after your deactivation provided you apply for reinstatement and you are otherwise eligible.

Such reinstatement will be without the application of a new waiting period. The remainder of any waiting period which existed prior to interruption of coverage may still be applied.

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

**CERTIFICATE RIDER –** Washington Residents

Rider Eligibility: Each Employee who is located in Washington

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

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

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

HC-ETWARDR

# Notice

Coordination of Benefits Included – See Table of Contents for Location of Coordination of Benefits Section. Your Benefits may be affected by other Insurance.

HC-CER1 02-16
V11-ET

# Customer Service

### HIPAA Privacy Statement

Your privacy is important to us. The following website explains how we collect and protect information about you:

**www.cigna.com/privacyinformation**

You may also request copies of this information by contacting customer service at the number shown on your ID card

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract or your rights under the law, you may contact the Office of Insurance Commissioner at 800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Health Department at 800-525-0127.

### Notice Regarding Coordination of Benefits

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

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

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

### American Indian Health Services

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

### Pharmacy Disclosures

Your Prescription Drugs Rights

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

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

   These provisions are explained in the **Prescription Drug Benefit** section of this certificate.
2. The **Prior Authorization Requirements** section of this certificate explains the process that you and your Physician must use to seek coverage of a Prescription Drug Product that is not on the Prescription Drug List or is not the preferred Prescription Drug Product for a covered medical condition.
3. You may be eligible to receive an emergency fill for a Prescription Drug Product at a non-Network Pharmacy if Cigna determines that the Prescription Order could not reasonably be filled at a Network Pharmacy. Your payment will be based on the Usual and Customary Charge submitted by the non-Network Pharmacy. You also may be eligible to receive an emergency fill for a Prescription Drug Product while a prior authorization request is being processed. The process for requesting this emergency fill and the cost share requirements for this emergency fill are described in the **Prescription Drug Benefit, Medication Synchronization and Emergency Fills Medication** section of this certificate.
4. The **Prescription Drug List Management and New Prescription Drug Products** sections in the **Prescription Drug Benefits** section of this certificate explain the process for developing coverage standards and the Prescription Drug Lists.
5. The **Prescription Drug List Management and New Prescription Drug Products** sections in **the Prescription Drug Benefits** section of this certificate explain the process for changing coverage standards and the Prescription Drug Lists. Additionally, the **Prior Authorization Requirements** section of this certificate explains the process that you and your Physician must use to seek coverage of a Prescription Drug Product that is not on the Prescription Drug List or is not the preferred Prescription Drug Product for a covered medical condition. The length of the authorization will depend on the diagnosis and Prescription Drug Product. There are instances when an approved Prescription Drug Product coverage exception may be grandfathered to allow ongoing coverage.
6. Coverage status of a Prescription Drug Product may change periodically. As a result of coverage changes the plan may require you to pay more or less for that Prescription Drug Product or try another covered Prescription Drug Product(s).
7. The Prescription Drug Product dispensing fee is considered to be a pharmacy-related service which is reimbursed by the plan.
8. The **Exclusion** section in the **Prescription Drug Benefits section of this certificate** lists the categories of excluded Prescription Drugs.

**Items to be Available on Request**

You may obtain copies of the following documents at www.cigna.com/product-disclosures, under Washington.

You may also request copies of the following documents by contacting customer service at the phone number listed on the back of your ID card, or by logging on to www.mycigna.com. Cigna will provide written information about this plan that includes the following information:

- any documents, instruments, or other information referred to in the Policy or certificate;
- Pharmacy question and answer document;
- a full description of the procedures to be followed by an insured for consulting a provider other than the primary care provider and whether the insured's primary care provider, or Cigna's medical director, or another entity must authorize the referral;
- procedures, if any, that an insured must first follow for obtaining prior authorization for health care services;
- a written description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between Cigna and a provider or network;
- descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to Specialists;

- an annual accounting of all payments made by Cigna which have been counted against any payment limitations, visit limitations, or other overall limitations on a insureds coverage under the plan; however, the individual requesting an annual accounting may only receive information about that individual's own care, and may not receive information pertaining to protected individuals who have requested confidential communications based on WA law;
- a copy of Cigna's grievance process for claim or service denial and for dissatisfaction with care; and
- accreditation status with one or more national managed care accreditation organizations, and whether Cigna tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data.
- access to and copies of all information relevant to a claim.
- the criteria, processes, strategies, evidentiary standards and other factors used to make medical necessity determinations of MH/SUD benefits and apply an NQTL to medical/surgical and MH/SUD benefits under the plan.
- a copy of the current Prescription Drug List.
- a list of participating primary care and specialty care providers.

Protected individual means: An adult covered as a dependent on the enrollee's health benefit plan, including an individual enrolled on the health benefit plan of the individual's registered domestic partner; or a minor who may obtain health care without the consent of a parent or legal guardian, based on state or federal law. It does not include an individual deemed not competent to provide informed consent for care.

HC-NOT116 01-20
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# Customer Service

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You may also request copies of this information by contacting customer service at the number shown on your ID card

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract or your rights under the law, you may contact the Office of Insurance Commissioner at 800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Health Department at 800-525-0127.

**Notice Regarding Coordination of Benefits**

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

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

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

**American Indian Health Services**

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

**Pharmacy Disclosures**

Your Prescription Drugs Rights

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

of health at 360-236-4700, www.doh.wa.gov, or HSQACSC@doh.wa.gov.

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   - 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.
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6. Coverage status of a Prescription Drug Product may change periodically. As a result of coverage changes the plan may require you to pay more or less for that Prescription Drug Product or try another covered Prescription Drug Product(s).
7. The Prescription Drug Product dispensing fee is considered to be a pharmacy-related service which is reimbursed by the plan.
8. The **Exclusion** section in the **Prescription Drug Benefits section of this certificate** lists the categories of excluded Prescription Drugs.

**Items to be Available on Request**

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You may also request copies of the following documents by contacting customer service at the phone number listed on the back of your ID card, or by logging on to www.mycigna.com. Cigna will provide written information about this plan that includes the following information:

- any documents, instruments, or other information referred to in the Policy or certificate;
- Pharmacy question and answer document;
- a full description of the procedures to be followed by an insured for consulting a provider other than the primary care provider and whether the insured's primary care provider, or Cigna's medical director, or another entity must authorize the referral;
- procedures, if any, that an insured must first follow for obtaining prior authorization for health care services;
- a written description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between Cigna and a provider or network;
- descriptions and justifications for provider compensation programs, including any incentives or penalties that are

intended to encourage providers to withhold services or minimize or avoid referrals to Specialists;

- an annual accounting of all payments made by Cigna which have been counted against any payment limitations, visit limitations, or other overall limitations on a insureds coverage under the plan; however, the individual requesting an annual accounting may only receive information about that individual's own care, and may not receive information pertaining to protected individuals who have requested confidential communications based on WA law;
- a copy of Cigna's grievance process for claim or service denial and for dissatisfaction with care; and
- accreditation status with one or more national managed care accreditation organizations, and whether Cigna tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data.
- access to and copies of all information relevant to a claim.
- the criteria, processes, strategies, evidentiary standards and other factors used to make medical necessity determinations of MH/SUD benefits and apply an NQTL to medical/surgical and MH/SUD benefits under the plan.
- a copy of the current Prescription Drug List.
- a list of participating primary care and specialty care providers.

Protected individual means: An adult covered as a dependent on the enrollee's health benefit plan, including an individual enrolled on the health benefit plan of the individual's registered domestic partner; or a minor who may obtain health care without the consent of a parent or legal guardian, based on state or federal law. It does not include an individual deemed not competent to provide informed consent for care.

HC-NOT118 01-20
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**Your Rights and Protections Against Surprise Medical Bills and Balance Billing**

*When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.*

**What is "balance billing" (sometimes called "surprise billing")?**

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. "Out-of-network" providers may be permitted to bill you the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing". This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you take an  ambulance ride, have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you, via their websites or if you ask, which providers, hospitals, and facilities are in their networks. Hospitals, surgical facilities, providers, behavioral health emergency services providers and ground ambulance providers must tell you which provider networks they participate in on their website or if you ask.

**You are protected from balance billing for:**

**Emergency Services**

If you have an emergency medical condition, mental health or substance use disorder 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 ground or air ambulance rides, and care you receive in a hospital or 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 a 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 emergency behavioral health services providers, and ground or 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 Washington State Office of the Insurance Commissioner's website for more information about your rights under Washington state law.

HC-NOT144 01-26
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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: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at:

https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status

or by phone at 1.800.562.6900, 1.360.586.0241 (TDD).

Complaint forms are available at:

https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx

HC-NOT127 01-21
ET

**Health Care Benefit Manager**

A health care benefit manager ("HCBM") is any person or entity that provides services to or acts on behalf of a health carrier or employee benefits program. HCBMs directly or indirectly impact the determination or use of benefits for or patient access to health care services, drugs and supplies.

HCBMs include, but are not limited to, specialized benefit types such as pharmacy, radiology, laboratory and mental health. The services of an HCBM also include: Prior authorization or preauthorization of benefits or care, certification of benefits or care, medical necessity determinations, utilization review, benefit determinations, claims processing and repricing for services and procedures, outcome management, provider credentialing and re-credentialing, payment or authorization of payment to providers and facilities for services or procedures, dispute resolution, grievances or appeals relating to determinations or utilization of benefits, provider network management and disease management.

A current list of HCBMs for your plan is available at www.cigna.com/product-disclosures.

HC-NOT128 01-21
ET

# Eligibility - Effective Date

**Exception for Newborns**

Any Dependent child born while you are insured for Medical Insurance will be automatically insured for Medical Insurance for the first 31 days of life. If payment of an additional premium is required to provide coverage for a child, to continue coverage beyond 31days, you must elect Dependent Medical Insurance for your newborn child within the 60 day enrollment period which begins on the first day of birth. If Dependent Medical Insurance is not elected within the 60 day enrollment period, you may be required to wait until the next plan enrollment period to enroll the child for coverage under the plan. Coverage shall include, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth.

HC-ELG395 01-26
V1-ET

# Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

**Opportunity to Select a Primary Care Physician**

For children, you may designate a pediatrician as the Primary Care Physician.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which you requested the change.

HC-IMP1
V10-ET

## The Schedule

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

**Hearing Aids**

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

SCHED WA ET7

**Continuity of Care**

- There may be instances in which your Participating Provider becomes unaffiliated with Cigna's network. In such cases you will be notified and provided assistance with selecting a new provider.
- However, under special medical circumstances, you may be able to continue seeing your provider, even though he or she is no longer affiliated with Cigna. This allows continued, uninterrupted care until safe transfer to a Participating Provider can be arranged. If you are undergoing an active course of treatment for an acute or chronic condition and continued treatment is Medically Necessary, you may be eligible to receive continuing care from the non-Participating Provider for at least 60 days or until the end of the next open enrollment period, subject to the treating provider's agreement. You may also be eligible to receive continuing care if you are in your second or third trimester of pregnancy. In this case, continued care may be extended through your delivery and include a period of postpartum care.
- You may request continuity of care from Cigna after your Participating Provider's termination. Continuity of care must be Medically Necessary and approved in advance by Cigna. Your provider must agree to accept our reimbursement rate and to abide by Cigna's policies and procedures and quality assurance requirements. Continuity of care will cease if your treatment is successfully transitioned to a Participating Provider.
- There may be circumstances when continued care by a provider no longer participating in Cigna's network will not be available, such as when the provider loses his or her license, is terminated for cause, or retires.

HC-PAC99 01-19

## Covered Expenses

- charges for ground Ambulance transports to behavioral health emergency services providers.
- charges made in connection with mammograms for breast cancer screening, diagnostic and supplemental mammography including digital breast tomosynthesis (3-D mammography) if prescribed by a Physician, an advanced registered nurse practitioner or a physician assistant.
- charges made for screening prostate-specific antigen (PSA) testing.
- charges for colorectal cancer screenings for all adults aged 45 to 49 years, and aged 50 to 75 years in accordance with the recommendations from the United States Preventative Services Task Force (USPSTF) of the Federal Centers for Disease Control and Prevention.
- charges for elective and non-elective abortion services.
- charges for Men's family planning, counseling, testing and sterilization (e.g. vasectomies).
- charges made for a drug that has been prescribed to treat a life-threatening illness for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be covered, provided: (a) it is recognized for the specific type of illness for which the drug has been prescribed in any one of the following established reference compendia: United States Pharmacopeia Drug Information; American Medical Association Drug Evaluation; American Hospital Formulary Service; other compendia identified by state or federal government; the majority of related peer-reviewed medical literature; or the Federal Secretary of Health and Human Services; (b) the drug has been otherwise approved by the FDA; and (c) the drug has not been contraindicated by the FDA for the use prescribed.
- 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.
- charges made for hearing aids and associated exam for device testing and fitting, including but not limited to semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies and delivers speech and other sounds at levels equivalent to that of normal speech and conversation.
- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage or oral contraceptives.

**Virtual Physician Services**

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

**Enteral Nutrition**

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

Coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism (e.g., disorders of amino acid or organic acid metabolism) including phenylketonuria (PKU) and Medically Necessary elemental formula, regardless of delivery method, when a licensed provider with prescriptive authority diagnoses a patient with an eosinophilic gastrointestinal associated disorder and orders and supervises the use of the elemental formula.

HC-COV1747 01-26

ET1

# The Schedule

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

**Abortion Drugs**

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

SCHEDPHARM90-waet3

# The Schedule

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

**Epinephrine Auto-Injector Device**

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

SCHEDPHARM90-waet4

## The Schedule

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

**Prescription Asthma Inhaler**

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

SCHEDPHARM90-waet5

## The Schedule

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

**HIV Post-Exposure Prophylactic Drugs**

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

SCHEDPHARM90-waet6

## The Schedule

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

Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your Deductible and counts toward your Out-of-Pocket Maximum.

Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your Deductible and counts towards your Out-of-Pocket Maximum.

SCHEDPHARM90-waet7

# Prescription Drug Benefits

## Limitations

**Prescription Topical Ophthalmic Products**

A pharmacist may, without consulting a Physician or obtaining a new prescription or refill authorization from a Physician, provide for one early refill of a prescription for topical ophthalmic products if:

- the refill is requested by a patient at or after seventy percent of the predicted days of use of :
  - the date the original prescription was dispensed to the patient; or
  - the date that the last refill of the prescription was dispensed to the patient;
- the prescriber indicates on the original prescription that a specific number of refills will be needed; and
- the refill does not exceed the number of refills that the prescriber indicated.

**Medication Synchronization and Emergency Fills Medication**

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

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

- for less than a one-month supply of the Prescription Drug or Related Supply if synchronization will require more than a fifteen-day supply of the Prescription Drug or Related Supply; or
- for more than a one-month supply of the Prescription Drug or Related Supply if synchronization will require a fifteen-day supply of the Prescription Drug or Related Supply or less.

Upon your request, the prescribing provider or pharmacist shall:

- Determine that filling or refilling the prescription is in your best interest, taking into account the appropriateness of synchronization for the drug being dispensed;
- Inform you that the prescription will be filled to less than the standard refill amount for the purpose of synchronizing your medications; and
- Deny synchronization on the grounds of threat to patient safety or suspected fraud or abuse.

Emergency fill refers to a limited dispensed amount of medication that allows time for the processing of a prior authorization request. If you or your Dependent request an emergency fill, the authorized amount of the emergency fill will be no more than the prescribed amount up to a seven day

supply or the minimum packaging size available at the time the emergency fill is dispensed.

Emergency fill only applies to those circumstances where a patient presents at a Participating Pharmacy with an immediate therapeutic need for a prescribed medication that requires a prior authorization. An emergency fill does not necessarily constitute a covered health service under this plan. Determination as to whether the emergency fill is a covered health service under this plan will be made as part of the prior authorization process.

The cost sharing for a Prescription Drug or Related Supply subject to coinsurance that is dispensed for less than the standard refill amount for the purpose Medication Synchronization or emergency fills will be adjusted. The cost sharing for Prescription Drug or Related Supply with a copayment that is dispensed for less than the standard refill amount for the purpose of purpose Medication Synchronization or emergency fills will be adjusted by:

- Dividing the insured's copayment for the drug by the normal day supply for the medication to find the Daily Member Cost.
- Multiply the Daily Insured Cost of the drug by the day supply being used. This is the amount Cigna will use to apply for the copayment.

**Prior Authorization Requirements**

If a prior authorization request is approved, your Physician will receive confirmation within forty-eight hours for an urgent care review, and within 5 calendar days for a non-urgent care review. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drug Products. The length of the authorization will depend on the diagnosis and Prescription Drug Products. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Products has been approved, you can contact the Pharmacy to fill the covered Prescription Order or Refill.

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

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

**Drug Substitution**

FDA approved Prescribed Drug Products that are the sole prescription drug available for a covered medical condition will be covered. Coverage for a non-Prescription Drug List Prescription Drug Product will not be excluded if the only Prescription Drug List drug available for your covered condition is one that you cannot tolerate or that is not clinically efficacious for you.

**Supply Limits**

You may obtain a twelve-month refill of covered contraceptive drugs if prescribed by your provider or you may request a smaller supply. If available, you may receive the contraceptives on site at the doctor's office. During the last quarter of the plan year the refill amount may be limited if a twelve-month supply of the contraceptive drug has already been dispensed during the plan year.

HC-PHR878 01-26
ET

## Your Payments

**Deductible**

Your plan requires that you pay the costs for covered Prescription Drug Products up to the Deductible amount set forth in The Schedule. Until you meet that Deductible amount, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy will be the lowest of the following amounts:

- the Copayment for the Prescription Drug Product set forth in The Schedule; or
- the Prescription Drug Charge; or
- the Pharmacy Rate; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

The Schedule sets forth your costs for covered Prescription Drug Products after you have satisfied the Deductible amount.

**Copayment**

Your plan requires that you pay a Copayment for covered Prescription Drug Products as set forth in The Schedule. After satisfying any applicable annual Deductible set forth in The Schedule, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy and that is subject to a Copayment requirement will be the lowest of the following amounts:

- the Copayment for the Prescription Drug Product set forth in The Schedule; or
- the Prescription Drug Charge; or
- the Pharmacy Rate; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.
- the Pharmacy Rate; or

HC-PHR879 01-26 ET

# Prescription Drug Benefits

## Exclusions

- vitamins, except FDA approved prenatal vitamins unless coverage for such product(s) is required by federal or state law.

HC-PHR819 01-25 ET

# Exclusions, Expenses Not Covered and General Limitations

## Exclusions and Expenses Not Covered

- for or in connection with experimental, investigational or unproven services or costs demonstrated to be associated with an adverse effect that is a result of receiving the investigational product.

  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 either:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.
  - any unproven or investigational services and supplies, including all related services and supplies or costs demonstrated to be associated with an adverse effect that is a result of receiving the investigational product.

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

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician relies on the coverage policies maintained by Cigna or the Review Organization. Coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.
- charges for health care services, supplies, or medications when billed for conditions or diagnoses that are not covered or reimbursable under the coverage policies maintained by Cigna or the Review Organization.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem. Cosmetic surgery and therapy does not include gender affirmation services.

- aids or devices or other adaptive equipment that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- all nutritional supplements, formulae, enteral feedings, supplies and specially formulated medical foods, whether prescribed or not, except for infant formula needed for the treatment of inborn errors of metabolism and as specifically provided in the "Enteral Nutrition" benefit.

HC-EXC680 01-26
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# Payment of Benefits

**Recovery of Overpayment**

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person or facility to whom it was made; or offset the amount of that overpayment from a future claim payment.

Except in the case of fraud, when an overpayment has been made by Cigna to a healthcare provider, Cigna will not have the right to:

(a) Request a refund from a healthcare provider of a payment previously made to satisfy a claim unless the request is made in writing to the provider within twenty-four months after the date that the payment was made; or

(b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why Cigna believes the provider owes the refund. If a provider fails to contest the request in writing to Cigna within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

Cigna will not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim:

(a) Request a refund from a healthcare provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within thirty months after the date that the payment was made; or

(b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why Cigna believes the provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If a provider fails to contest the request in writing to Cigna within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

Cigna may at any time request a refund from a healthcare provider of a payment previously made to satisfy a claim if:

(a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and

(b) Cigna is unable to recover directly from the third party because the third party has either already paid or will pay the provider for the health services covered by the claim.

HC-POB225 01-26
ET

# Termination of Insurance

**Continuation of Insurance During Strike, Lockout or Other Labor Dispute**

If your Medical Insurance will end due to a strike, lockout, or other labor dispute, under Washington law, you may elect to continue medical benefits for yourself and your insured Dependents. Your Employer will notify you of your right to continue your medical coverage. This notice will specify the amount of your premium payment, when your premium payments are due and the address to mail your payment. You must complete the application included with the notice and return it to your Employer with the required premium.

Medical benefits for your continued coverage will be those in effect on the day before the labor dispute began.

Your medical coverage will be continued until the earlier of:

- the last day for which you have made any required contribution for the insurance;
- the date the group policy terminates;
- the end of a period 6 months from the date your continued coverage began.

You must notify your Employer in writing if you become eligible for other group medical coverage prior to the end of the continuation period.

HC-TRM109 ET

## Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)

Although federal law does not extend FMLA rights to Domestic Partners, this plan will extend these same continuation benefits to Domestic Partners (and their children if not legal children of the Employee) to the same extent they are provided to spouses and legal children of the Employee.

HC-FED99 01-24
V3-ET

## Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

**Reinstatement of Benefits (applicable to all coverages)**

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this Plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

Although federal law does not extend USERRA rights to Domestic Partners, this plan will extend these same continuation benefits to Domestic Partners (and their children if not legal children of the Employee) to the same extent they are provided to spouses and legal children of the Employee.

HC-FED100 01-26
V3-ET

## Definitions

**Concurrent Care Coverage Determination**

Concurrent Care Coverage Determination means a medical necessity determination that is made during the period when the health care services or supplies are being provided to a customer including a) during on-going inpatient, intensive outpatient or residential behavioral healthcare treatment, b) during ongoing ambulatory care.

HC-DFS871 ET

**Dependent**

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability.

    Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. The plan may require proof not more frequently than annually after the two year period following the child's attainment of the limiting age.

The term child means a child born to you or a child legally adopted by you including a child for whom you assume legal obligation for total or partial support, in anticipation of

adoption, but with no requirement that the adoption be final. It also includes a stepchild. If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent or Dependent spouse unless the Dependent or Dependent spouse declines Employee coverage. A child under age 26 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee.

No one may be considered as a Dependent of more than one Employee.

HC-DFS1758 01-22 ET

**Domestic Partner**

A Domestic Partner is defined as a person who has a valid domestic partner registration in Washington.

HC-DFS1608 01-21 ET

**Prescription Drug Product**

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

HC-DFS2089 01-25 ET

**Related Supplies**

Related Supplies means diabetic supplies (insulin needles and syringes, lancets, injection aids, test strips for glucose monitors, visual blood sugar reading and urine testing strips, prescriptive oral agents for controlling blood sugar levels, glucogen emergency kits), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

HC-DFS68 V7-ET

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

**CERTIFICATE RIDER –** West Virginia Residents

Rider Eligibility: Each Employee who is located in West Virginia

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

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

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

HC-ETWVRDR

**Important Information**

**Rebates and Other Payments**

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

affiliates must pass 100% of the value of such rebates or other remuneration to you to reduce your Deductible or Coinsurance that you pay at the Point-of-Sale for Medical Pharmaceuticals covered under your plan and Prescription Drug Products included on the Prescription Drug List Cigna and its affiliates must use any amounts over and above your Deductible or Coinsurance to reduce the cost of future premiums.

**Coupons, Incentives and Other Communications**

At various times, Cigna or its designee may send mailings to you or your Dependents or to your Physician that communicate a variety of messages, including information about Medical Pharmaceuticals and Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you or your Dependents, at your discretion, to purchase the described Medical Pharmaceutical and Prescription Drug Product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Cigna, its affiliates and the plan are not responsible in any way for any decision you make in connection with any coupon, incentive, or other offer you may receive from a pharmaceutical manufacturer or Physician.

HC-IMP445 01-25 ET

## Limitations

### Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. Specialty Prescription Drug Products can come from any Network Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products.

HC-PHR806 01-25 ET

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

**CERTIFICATE RIDER** – Wisconsin Residents

Rider Eligibility: Each Employee who is located in Wisconsin

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 Wisconsin group insurance plans covering insureds located in Wisconsin. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

GM6000 HC-ETWIRDR

## Termination of Insurance

### Special Continuation of Medical Insurance

If your insurance ceases for any reason other than discontinuance of the policy; failure to make any required contributions; or termination of employment due to misconduct; and if you have been insured for at least three consecutive months, you may continue your Medical Insurance by paying the required premiums to the Employer. In no event will the insurance be continued beyond the earliest of the following dates:

- 18 months from the date the insurance would otherwise cease;
- the last day for which you have paid the required premium;
- the date you become eligible for similar group coverage;
- the date the group policy cancels.

If your insurance is being continued as described above, the Medical Insurance for any one of your Dependents insured on the date your insurance would otherwise cease may be continued under the same conditions shown above, until the

date your insurance ceases or, with respect to any one Dependent, the date that Dependent ceases to qualify as a Dependent, whichever comes first.

**For Dependents of Deceased Employee**

If you die while insured, your Dependents who are insured at the time of your death may continue their Medical Insurance by paying the required premium to the Employer, but in no event beyond the earliest of the following dates:

- 18 months from the date of your death;
- the last day for which the required premium has been paid;
- with respect to any one Dependent, the date that Dependent becomes eligible for similar group coverage; or the date that Dependent ceases to qualify as a Dependent for any reason other than lack of primary support by you;
- the date the policy cancels.

**For Spouse Upon Divorce From Employee**

If your spouse's Medical Insurance would otherwise terminate because of divorce or annulment of marriage, your former spouse may continue the insurance by paying the required contribution to the Employer, but in no event beyond the earliest of the following dates:

- 18 months from the date the insurance would otherwise cease;
- the last day for which the required contribution has been paid;
- the date that your former spouse becomes eligible for similar group coverage;
- the date you are no longer insured under the policy;
- the date this policy cancels.

If the insurance on your former spouse is being continued under a group policy that was replaced by this policy, such spouse will be eligible for continuance under this policy, subject to the other provisions of this policy. However, the insurance will not be continued beyond a period of time totaling more than 18 months under both policies combined.

**Notification of Special Continuation**

The Employer will notify in writing any eligible person, within five days after the date that person's insurance would otherwise cease, of his right to elect the continuation. The eligible person may elect the continuation by applying in writing and sending the required contribution to the Employer within 30 days after the day he receives written notice of his option to continue his insurance.

**Conversion Available Following Continuation**

The terms of the "Medical Conversion Privilege" section will apply following the termination of insurance.

The terms of this section will not reduce any continuation of insurance otherwise provided.

HC-TRM59 04-10
V1-ET

# Definitions

**Grievance**

The term Grievance means any written dissatisfaction by you or your Dependent with Cigna's administration, claims practices or provision of services.

HC-DFS221 04-10
V1-ET