

Pla-Fit Franchise LLC

ANNUAL COMPLIANCE RIDER

EFFECTIVE DATE: January 1, 2025

ACNHM25

3345932

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

Printed in U.S.A.

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

ANNUAL COMPLIANCE RIDER

No. ACNHM25

Policyholder: Pla-Fit Franchise LLC

Rider Eligibility: Each Employee

Policy No. or Nos. 3345932-HR1, HR2, HSF/HSI, OAP

Effective Date: January 1, 2025

This Annual Compliance Rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified above.

This Annual Compliance Rider replaces any other Annual Compliance Rider issued to you on a prior date.

The provisions set forth in this Annual Compliance Rider comply with legislative requirements of the State of New Hampshire regarding group insurance plans covering insureds. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

READ THE FOLLOWING

NOTE: The provisions identified in this rider are specifically applicable ONLY for:

- Benefit plans which have been made available by your Employer to you and/or your Dependents;
- Benefit plans for which you and/or your Dependents are eligible;
- Benefit plans which you have elected for you and/or your Dependents;
- Benefit plans which are currently effective for you and/or your Dependents.



Geneva Cambell Brown, Corporate Secretary



Federal CAA - Consolidated Appropriations Act and TIC - Transparency in Coverage Notice

The following paragraphs have been added to the **Important Notices** section of your medical certificate:

Cigna will make available an internet-based self-service tool for use by individual customers, as well as certain data in machine-readable file format on a public website, as required under the Transparency in Coverage rule. Customers can access the cost estimator tool on myCigna.com. Updated machine-readable files can be found on Cigna.com and/or CignaForEmployers.com on a monthly basis.

Pursuant to Consolidated Appropriations Act (CAA), Section 106, Cigna will submit certain air ambulance claim information to the Department of Health and Human Services (HHS) in accordance with guidance issued by HHS.

Subject to change based on government guidance for CAA Section 204, Cigna will submit certain prescription drug and health care spending information to HHS through Plan Lists Files (P1-P3) and Data Files (D1-D8) (D1-D2) for an Employer without an integrated pharmacy product aggregated at the market segment and state level, as outlined in guidance.

HC-IMP324

01-23
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Federal CAA - Consolidated Appropriations Act

The following paragraphs have been added to the **Important Notices** section of your medical certificate:

Continuity of Care

In certain circumstances, if you are receiving continued care from an in-network provider or facility, and that provider's network status changes from in-network to out-of-network, you may be eligible to continue to receive care from the provider at the in-network cost-sharing amount for up to 90 days from the date you are notified of your provider's termination. A continuing care patient is an individual who is:

- Undergoing treatment for a serious and complex condition
- Pregnant and undergoing treatment for the pregnancy
- Receiving inpatient care
- Scheduled to undergo urgent or emergent surgery, including postoperative
- Terminally ill (having a life expectancy of 6 months or less) and receiving treatment from the provider for the illness

If applicable, Cigna will notify you of your continuity of care options.

Appeals

Any external review process available under the plan will apply to any adverse determination regarding claims subject to the No Surprises Act.

Provider Directories and Provider Networks

A list of network providers is available to you, without charge, by visiting the website or calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as generic practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

A list of network pharmacies is available to you, without charge, by visiting the website or calling the phone number on your ID card. The network consists of pharmacies affiliated or contracted with Cigna or an organization contracting on its behalf.

Provider directory content is verified and updated, and processes are established for responding to provider network status inquiries, in accordance with applicable requirements of the No Surprises Act.

If you rely on a provider's in-network status in the provider directory or by contacting Cigna at the website or phone number on your ID card to receive covered services from that provider, and that network status is incorrect, then your plan cannot impose out-of-network cost shares to that covered service. In-network cost share must be applied as if the covered service were provided by an in-network provider.

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, access the website or call the phone number on your ID card.

Selection of a Primary Care Provider

This plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for

a list of the participating primary care providers, access the website or call the phone number on your ID card.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these situations, you should not be charged more than your plan's copayments, coinsurance, and/or deductible.

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 deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or annual out-of-pocket limit.

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

You are protected from balance billing for:

- **Emergency services** – If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as a copayments, coinsurance, and deductibles). You cannot be balanced billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- **Certain non-emergency 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 those providers can bill you is your plan's in-network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or

intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balanced billed.

If you get other types of services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you have these protections:

- You are only responsible for paying your share of the cost (such as copayments, coinsurance, and deductibles that you would pay if the provider were in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval in advance for services (also known as prior authorization).
 - Cover emergency services provided 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 (EOB).
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you have been wrongly billed, contact Cigna at the phone number on your ID card. You can also contact No Surprises Help Desk at 1-800-985-3059 or <http://www.cms.gov/nosurprises> for more information about your rights under federal law.

HC-IMP325

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Important Notices

The following language regarding "New Hampshire Patient Bill of Rights" found in the **Important Notices** section is being revised to read as follows:

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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The Schedule

The following paragraphs regarding “Out-of-Network Charges for Certain Services” are hereby added to **The Schedule** of your medical certificate as a result of the **Consolidated Appropriations Act - No Surprise Bill**:

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.

SCHED - FED

AC70

The Schedule

Any existing paragraphs regarding “Out-of-Network Emergency Services Charges” in **The Schedule** of your medical certificate are hereby replaced as follows as a result of the **Consolidated Appropriations Act - No Surprise Bill**:

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.

SCHED - FED

AC71

The Schedule

The medical schedule is amended to add the following paragraphs as a result of the Consolidated Appropriations Act – Air Ambulance:

Out-of-Network Air Ambulance Services Charges

1. Covered air ambulance services are payable 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 air ambulance services rendered by an Out-of-Network provider 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.

SCHED - FED

AC93

The Schedule

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

Maximum Reimbursable Charge

For Out-of-Network services, other than those described in The Schedule sections Out-of-Network Charges for Certain Services and Out-of-Network Emergency Services Charges and Out-of-Network Air Ambulance Services Charges, see Definitions section for an explanation of Maximum Reimbursable Charge. For Out-of-Network benefits, in addition to applicable Deductibles, Copayments, and Coinsurance amounts, you are responsible for any charges above the Maximum Reimbursable Charge.

SCHED - FED

AC114

The Schedule

The following text is hereby added to any covered Out-of-Network benefit that includes a Coinsurance amount in **The Schedule** of your medical certificate (this text does not apply to Air Ambulance or Emergency Services as a result of the **Consolidated Appropriations Act - No Surprise Bill**):
“of the Maximum Reimbursable Charge”.

SCHED - FED

AC77

The Schedule

The medical schedule is amended to add the provision “Air Ambulance” as a result of the Consolidated Appropriations Act – Air Ambulance:

Coverage will be the same In-Network and Out-of-Network.

Air Ambulance

Subject to any plan coinsurance and plan deductible

SCHED - FED

AC 87

Covered Expenses

The following bullets regarding abortion gestational age found in the **Covered Expenses** section has been added in your medical certificate:

- charges for all necessary medical examinations, imaging studies, and tests required to make a gestational age determination prior to an abortion.

HC-COV1300

01-23

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Covered Expenses

The following bullet regarding “the treatment of cancer by autologous bone marrow transplants” found in the **Covered Expenses** section of your medical certificate is hereby NULL and VOID:

- charges for the treatment of cancer by autologous bone marrow transplants, which follows the protocols reviewed and approved by the National Cancer Institute.

The following bullet regarding “child early intervention services” found in the **Covered Expenses** section of your medical certificate is hereby NULL and VOID:

- charges for expenses arising from the services of licensed and credentialed occupational therapists, physical therapists, speech-language pathologists, and clinical social workers working with children from birth to age 3 with an identified developmental disability and/or delay as long as the providing therapist receives a referral from the child's Primary Care Physician, if applicable.

The following bullet regarding “contraceptives” is added to the **Covered Expenses** section of your medical certificate:

- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage on oral contraceptives.



The following bullet replaces the text and bullets regarding “diabetes equipment, supplies and training” found in the **Covered Expenses** section of your medical certificate:

- charges for Medically Necessary diabetic equipment and outpatient self-management training and educational services.

HC-COV1388

01-24
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Covered Expenses

The language below regarding “Mental Health and Substance Use Disorder Services” found in the **Covered Expenses** section has been added in your medical certificate:

Mental Health and Substance Use Disorder Services

Inpatient Mental Health Services

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.

HC-COV1389

01-24
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Covered Expenses

The following bullet regarding the individual provides medical and scientific information found in the **Covered Expenses** section of your medical certificate is being revised to read as follows:

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

HC-COV1016

01-21
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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

AC14

Prescription Drug Benefits

Limitations

The following language found under “Limitations” in the **Prescription Drug Benefits** section of your medical certificate is being revised to read as follows:

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.

HC-PHR649

01-24
AC

Prescription Drug Benefits

Limitations

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

Prior Authorization Requirements

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

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

HC-PHR612

01-23
AC

Coordination of Benefits

The “Important” language found in the **Coordination of Benefits** of your medical certificate has been revised to read as follows:

IMPORTANT: If you, your spouse, or your Dependent do not elect to enroll in Medicare Part B when first eligible, or you receive services from a provider who does not accept Medicare payments, this Plan will calculate payment based

on what should have been paid by Medicare Part B as the primary payer if the person had been enrolled or had received services from a provider who accepts Medicare payments. A person is considered eligible for Medicare Part B on the earliest date any coverage under Medicare Part B could become effective.

HC-COB313

06-21
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Payment of Benefits

The paragraph regarding “Time of Payment” found in the **Covered Expenses** section has been added in your medical certificate:

Time of Payment

Benefits will be paid by Cigna when it receives due proof of loss.

Payments will be made within 30 calendar days upon receipt of a clean non-electronic claim or 15 calendar days upon receipt of a clean electronic claim.

HC-POB181

01-24
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Definitions

The following replaces the definition of “Emergency Services” shown in the **Definitions** section of your medical certificate as a result of the **Consolidated Appropriations Act – No Surprise Bill**:

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.

HC-DFS1763

01-23
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Definitions

The bullet regarding diabetic supplies is being added in the “Prescription Drug Product” under the **Definition** section of your medical certificate:

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:

- Medically Necessary and appropriate diabetic supplies;

HC-DFS1829

01-24
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Definitions

The following replaces the definition of “Stabilize” shown in the **Definitions** section of your medical certificate as a result of the **Consolidated Appropriations Act - No Surprise Bill**:

Stabilize

Stabilize means, with respect to an Emergency Medical Condition, to provide medical treatment as necessary to assure that no material deterioration of the condition is likely if the individual is transferred from a facility, or, with respect to a pregnant woman who is having contractions, to deliver.

HC-DFS1767

01-23
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The following Federal Requirements replace any such provisions shown in your Certificate.

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

HC-FED1

10-10 AC

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage elections

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

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

B. Change of status

A change in status is defined as:

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

C. Court order

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

D. Medicare or Medicaid eligibility/entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or



enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in cost of coverage

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

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

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

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

G. Reduction in work hours

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

H. Enrollment in a Qualified Health Plan (QHP)

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

Family: A plan may allow an Employee to revoke family coverage midyear in order for family members ("related individuals") to enroll in a QHP through an Exchange (Marketplace). The related individual(s) must be eligible for a Special Enrollment Period to enroll in a QHP or seek to enroll in a QHP during the Marketplace's annual open enrollment period, and the disenrollment from the group plan corresponds to the intended enrollment of the individual(s) in a QHP for new coverage effective beginning no later than the day immediately following the last day of the original coverage. If

the Employee does not enroll in a QHP, the Employee must select self-only coverage or family coverage including one or more already-covered individuals.

HC-FED111

01-23

AC

Women's Health and Cancer Rights Act (WHCRA)

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

HC-FED12

10-10

AC



Home Office: Bloomfield, Connecticut

Mailing Address: 900 Cottage Grove Road, Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

No. CR7BI003-1

Policyholder: Pla-Fit Franchise LLC

Rider Eligibility: Each Employee as reported to the insurance company by your Employer

Policy No. or Nos. 3345932-OAP

Effective Date: January 1, 2025

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

A handwritten signature in black ink, appearing to read "Geneva Cambell Brown".

Geneva Cambell Brown, Corporate Secretary

HC-RDR1

04-10
V11



The following are being added to THE SCHEDULE — **Open Access Plus Medical Benefits** — in your certificate under the sections entitled **Advanced Cellular Therapy**.

The page in your certificate coded **HC-COV1013** is replaced by the page coded **HC-COV1325** attached to this certificate rider.

The page coded **HC-COV1326** attached to this certificate rider is added to your certificate.

Open Access Plus Medical Benefits

The Schedule

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Advanced Cellular Therapy Includes prior authorized advanced cellular therapy products and related services when Medically Necessary. Advanced Cellular Therapy Product Covered Same as Medical Pharmaceuticals In-Network coverage only Inpatient Facility Plan deductible, then 70% In-Network coverage only Outpatient Facility Plan deductible, then 70% In-Network coverage only Inpatient Professional Services Plan deductible, then 70% In-Network coverage only Outpatient Professional Services Plan deductible, then 70% In-Network coverage only Advanced Cellular Therapy Travel 100% In-Network coverage only Maximum: \$10,000 per episode of advanced cellular therapy (Available only for travel when prior authorized to receive advanced cellular therapy from a provider located more than 60 miles of your primary residence and is contracted with Cigna for the specific advanced cellular therapy product and related services.)		

Open Access Plus Medical Benefits

Transplant Services and Related Specialty Care

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

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral. Implantation procedures for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO), ventricular assist device (VAD), and intra-aortic balloon pump (IABP) are also covered.

- 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 Participating Provider facilities specifically contracted with Cigna for those transplant services and related specialty care services, other than Cigna LifeSOURCE Transplant Network® facilities, are payable at the In-Network level.
- Transplant services and related specialty care services received at any other facility, including non-Participating Provider facilities and Participating Provider facilities not specifically contracted with Cigna for transplant services and related specialty care services, are not covered.
- Cornea transplants received at a facility that is specifically contracted with Cigna for this type of transplant are payable at the In-Network level.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of hospitalization and surgery necessary for removal of an organ and transportation of a live donor (refer to Transplant and Related Specialty Care Travel Services). Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant and Related Specialty Care Travel Services

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

- Transplant and related specialty care travel benefits are not available for cornea transplants.
- Benefits for transportation and lodging are available to the recipient of a pre-approved organ/tissue transplant and/or related specialty care from a designated Cigna LifeSOURCE Transplant Network® facility.
- The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care.
- Travel expenses for the person receiving the transplant will include charges for: transportation to and from the designated Cigna LifeSOURCE Transplant Network® facility (including charges for a rental car used during a period of care at the Cigna designated LifeSOURCE Transplant Network® facility); and lodging while at, or traveling to and from the Cigna LifeSOURCE Transplant Network® facility.
- In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.
- The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income; travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits for Transplant Services and Related Specialty Care, and for Transplant and Related Specialty Care Travel Services are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above.

Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant; the transplant recipient's plan would cover all donor costs.

Advanced Cellular Therapy

Charges for advanced cellular therapy products and services directly related to their administration are covered when Medically Necessary. Coverage includes the cost of the advanced cellular therapy product; medical, surgical, and facility services directly related to administration of the advanced cellular therapy product, and professional services.

Cigna determines which U.S. Food and Drug Administration (FDA) approved products are in the category of advanced cellular therapy, based on the nature of the treatment and how it is manufactured, distributed and administered. An example of advanced cellular therapy is chimeric antigen receptor (CAR) T-cell therapy that redirects a person's T cells to recognize and kill a specific type of cancer cell.

Advanced cellular therapy products and their administration are covered at the in-network benefit level when prior authorized to be received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services. 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 not covered.

Advanced Cellular Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized advanced cellular therapy product are covered, subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when:

- you are the recipient of a prior authorized advanced cellular therapy product;

- the term recipient is defined to include a person receiving prior authorized advanced cellular therapy related services during any of the following: evaluation, candidacy, event, or post care;
- the advanced cellular therapy products and services directly related to their administration are received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services; and
- the provider is not available within a 60 mile radius of your primary home residence.

Travel expenses for the person receiving the advanced cellular therapy include charges for: transportation to and from the advanced cellular therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 mile radius of your primary home residence; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

HC-COV1326

01-24



Home Office: Bloomfield, Connecticut

Mailing Address: 900 Cottage Grove Road, Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

No. CR7BI001-1

CR7BI005-1

Policyholder: Pla-Fit Franchise LLC

Rider Eligibility: Each Employee as reported to the insurance company by your Employer

Policy No. or Nos. 3345932-HR1, HR2

Effective Date: January 1, 2025

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

A handwritten signature in black ink, appearing to read "Geneva Cambell Brown".

Geneva Cambell Brown, Corporate Secretary

HC-RDR1

04-10
V11



The following is being added to THE SCHEDULE — **Open Access Plus Medical Benefits** — in your certificate under the section entitled **Advanced Cellular Therapy**.

The page in your certificate coded **HC-COV1013** is replaced by the page coded **HC-COV1325** attached to this certificate rider.

The page coded **HC-COV1326** attached to this certificate rider is added to your certificate.

Open Access Plus Medical Benefits

The Schedule

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Advanced Cellular Therapy Includes prior authorized advanced cellular therapy products and related services when Medically Necessary. Advanced Cellular Therapy Product Covered Same as Medical Pharmaceuticals In-Network coverage only Inpatient Facility Plan deductible, then 100% In-Network coverage only Outpatient Facility Plan deductible, then 100% In-Network coverage only Inpatient Professional Services Plan deductible, then 100% In-Network coverage only Outpatient Professional Services Plan deductible, then 100% In-Network coverage only Advanced Cellular Therapy Travel Maximum: \$10,000 per episode of advanced cellular therapy (Available only for travel when prior authorized to receive advanced cellular therapy from a provider located more than 60 miles of your primary residence and is contracted with Cigna for the specific advanced cellular therapy product and related services.) 100% In-Network coverage only		

Open Access Plus Medical Benefits

Transplant Services and Related Specialty Care

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

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral. Implantation procedures for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO), ventricular assist device (VAD), and intra-aortic balloon pump (IABP) are also covered.

- 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 Participating Provider facilities specifically contracted with Cigna for those transplant services and related specialty care services, other than Cigna LifeSOURCE Transplant Network® facilities, are payable at the In-Network level.
- Transplant services and related specialty care services received at any other facility, including non-Participating Provider facilities and Participating Provider facilities not specifically contracted with Cigna for transplant services and related specialty care services, are not covered.
- Cornea transplants received at a facility that is specifically contracted with Cigna for this type of transplant are payable at the In-Network level.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of hospitalization and surgery necessary for removal of an organ and transportation of a live donor (refer to Transplant and Related Specialty Care Travel Services). Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant and Related Specialty Care Travel Services

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

- Transplant and related specialty care travel benefits are not available for cornea transplants.
- Benefits for transportation and lodging are available to the recipient of a pre-approved organ/tissue transplant and/or related specialty care from a designated Cigna LifeSOURCE Transplant Network® facility.
- The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care.
- Travel expenses for the person receiving the transplant will include charges for: transportation to and from the designated Cigna LifeSOURCE Transplant Network® facility (including charges for a rental car used during a period of care at the Cigna designated LifeSOURCE Transplant Network® facility); and lodging while at, or traveling to and from the Cigna LifeSOURCE Transplant Network® facility.
- In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.
- The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income; travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits for Transplant Services and Related Specialty Care, and for Transplant and Related Specialty Care Travel Services are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above.

Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant; the transplant recipient's plan would cover all donor costs.

Advanced Cellular Therapy

Charges for advanced cellular therapy products and services directly related to their administration are covered when Medically Necessary. Coverage includes the cost of the advanced cellular therapy product; medical, surgical, and facility services directly related to administration of the advanced cellular therapy product, and professional services.

Cigna determines which U.S. Food and Drug Administration (FDA) approved products are in the category of advanced cellular therapy, based on the nature of the treatment and how it is manufactured, distributed and administered. An example of advanced cellular therapy is chimeric antigen receptor (CAR) T-cell therapy that redirects a person's T cells to recognize and kill a specific type of cancer cell.

Advanced cellular therapy products and their administration are covered at the in-network benefit level when prior authorized to be received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services. 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 not covered.

Advanced Cellular Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized advanced cellular therapy product are covered, subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when:

- you are the recipient of a prior authorized advanced cellular therapy product;

- the term recipient is defined to include a person receiving prior authorized advanced cellular therapy related services during any of the following: evaluation, candidacy, event, or post care;
- the advanced cellular therapy products and services directly related to their administration are received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services; and
- the provider is not available within a 60 mile radius of your primary home residence.

Travel expenses for the person receiving the advanced cellular therapy include charges for: transportation to and from the advanced cellular therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 mile radius of your primary home residence; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

HC-COV1326

01-24



Home Office: Bloomfield, Connecticut

Mailing Address: 900 Cottage Grove Road, Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

No. CR7BI002-1

Policyholder: Pla-Fit Franchise LLC

Rider Eligibility: Each Employee as reported to the insurance company by your Employer

Policy No. or Nos. 3345932-HSF/HSI

Effective Date: January 1, 2025

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

A handwritten signature in black ink, appearing to read "Geneva Cambell Brown".

Geneva Cambell Brown, Corporate Secretary

HC-RDR1

04-10
V11



The following is being added to THE SCHEDULE — **Open Access Plus Medical Benefits** — in your certificate under the section entitled **Advanced Cellular Therapy**.

The page in your certificate coded **HC-COV1013** is replaced by the page coded **HC-COV1325** attached to this certificate rider.

The page coded **HC-COV1326** attached to this certificate rider is added to your certificate.

Open Access Plus Medical Benefits

The Schedule

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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Open Access Plus Medical Benefits

Transplant Services and Related Specialty Care

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- Transplant services and related specialty care services received at Participating Provider facilities specifically contracted with Cigna for those transplant services and related specialty care services, other than Cigna LifeSOURCE Transplant Network® facilities, are payable at the In-Network level.
- Transplant services and related specialty care services received at any other facility, including non-Participating Provider facilities and Participating Provider facilities not specifically contracted with Cigna for transplant services and related specialty care services, are not covered.
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Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of hospitalization and surgery necessary for removal of an organ and transportation of a live donor (refer to Transplant and Related Specialty Care Travel Services). Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant and Related Specialty Care Travel Services

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

- Transplant and related specialty care travel benefits are not available for cornea transplants.
- Benefits for transportation and lodging are available to the recipient of a pre-approved organ/tissue transplant and/or related specialty care from a designated Cigna LifeSOURCE Transplant Network® facility.
- The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care.
- Travel expenses for the person receiving the transplant will include charges for: transportation to and from the designated Cigna LifeSOURCE Transplant Network® facility (including charges for a rental car used during a period of care at the Cigna designated LifeSOURCE Transplant Network® facility); and lodging while at, or traveling to and from the Cigna LifeSOURCE Transplant Network® facility.
- In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.
- The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income; travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits for Transplant Services and Related Specialty Care, and for Transplant and Related Specialty Care Travel Services are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above.

Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant; the transplant recipient's plan would cover all donor costs.

Advanced Cellular Therapy

Charges for advanced cellular therapy products and services directly related to their administration are covered when Medically Necessary. Coverage includes the cost of the advanced cellular therapy product; medical, surgical, and facility services directly related to administration of the advanced cellular therapy product, and professional services.

Cigna determines which U.S. Food and Drug Administration (FDA) approved products are in the category of advanced cellular therapy, based on the nature of the treatment and how it is manufactured, distributed and administered. An example of advanced cellular therapy is chimeric antigen receptor (CAR) T-cell therapy that redirects a person's T cells to recognize and kill a specific type of cancer cell.

Advanced cellular therapy products and their administration are covered at the in-network benefit level when prior authorized to be received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services. 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 not covered.

Advanced Cellular Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized advanced cellular therapy product are covered, subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when:

- you are the recipient of a prior authorized advanced cellular therapy product;
- the term recipient is defined to include a person receiving prior authorized advanced cellular therapy related services during any of the following: evaluation, candidacy, event, or post care;
- the advanced cellular therapy products and services directly related to their administration are received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services; and
- the provider is not available within a 60 mile radius of your primary home residence.

Travel expenses for the person receiving the advanced cellular therapy include charges for: transportation to and from the advanced cellular therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 mile radius of your primary home residence; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

HC-COV1326

01-24

Pla-Fit Franchise LLC

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2025

ETALLM25A
3345932

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

Printed in U.S.A.

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

CERTIFICATE RIDER

Policyholder: Pla-Fit Franchise LLC
Rider Eligibility: Each Employee as noted within this certificate rider
Policy No. or Nos.: 3345932
Effective Date: January 1, 2025

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 New Hampshire:

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

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

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

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

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

Geneva Cambell Brown, Corporate Secretary

HC-ETRDRV1



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

CERTIFICATE RIDER – 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 HealthCare 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-COV1429

01-23
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



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 – California Residents

Rider Eligibility: Each Employee who is located in California

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

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

The provisions set forth in this rider comply with the legal requirements of California for group insurance plans covering

insureds located in California. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETCARDR

Covered Expenses

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

HC-COV992

01-20
ET1

Clinical Trials

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

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

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

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

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

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

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

Examples of routine patient care costs and services include:

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

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

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

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

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

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

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

Standard's Clinical Pharmacology; (ii) The National Comprehensive Cancer Network Drug and Biologics compendium; (iii) The Thomson Micromedex DrugDex, (C) two articles from major peer-reviewed medical journals that that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

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

HC-EXC414

01-20
VI-ET1

Definitions

Domestic Partner

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

HC-DFS1024

10-16
ET

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

CERTIFICATE RIDER – Colorado Residents

Rider Eligibility: Each Employee who is located in Colorado

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

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

The provisions set forth in this rider comply with the legal requirements of Colorado group insurance plans covering

insureds located in Colorado. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETCORDER

Eligibility - Effective Date

Exception for Children

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

HC-ELG233

01-19
ET

The Schedule

The medical Schedule is amended to indicate the following:

Preventive Care (according to USPSTF recommendations)

- Childhood Immunizations and physical examinations through age 12

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

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

HPV (Human Papillomavirus) Vaccine

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

Colorectal Cancer Screening

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

SCHEDCO-ET1

The Schedule

The medical Schedule is amended to indicate the following:

Early Intervention Services

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

SCHEDCO-ET5

Covered Expenses

- charges made for the full cost of the three-dose series of cervical cancer vaccines for all females for whom a vaccination is recommended by the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services.
- charges by a Hospital for a mother and newborn for inpatient care for 48 hours following a vaginal delivery and 96 hours of care following a cesarean section. If the 48 or 96 hours falls after 8:00 p.m., then coverage will be continued until 8:00 a.m. the following morning. No authorization of care will be required for these time frames. For longer stays, guidelines prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists will be used. A shorter length of stay is acceptable if the decision for early discharge is made by the mother and the Physician.
- charges made for or in connection with management of pain for which a cause or cure cannot be found through reasonable efforts made by a Physician or Specialist.

HC-COV1438

01-24
ET

The Schedule

The pharmacy Schedule is amended to indicate the following:

Oral Chemotherapy Medication

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

SCHEDPHARM-ET

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

HC-EXC562

01-24
ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

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

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

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

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

HC-SUB135

01-21
ET

Definitions

Dependent

Dependents include:

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

HC-DFS1667

01-22
ET

Emergency Service Provider

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

HC-DFS236

04-10
VI-ET



Employee

The term Employee means an Employee as determined by your Employer who is currently in Active Service. The term Employee may include officers, managers and Employees of the Employer, the bona fide volunteers if the Employer is an Emergency Service Provider, the partners if the Employer is a partnership, the officers, managers, and Employees of subsidiary or affiliated corporations of a corporation Employer, and the individual proprietors, partners, and Employees of individuals and firms, the business of which is controlled by the insured Employer through stock ownership, contract, or otherwise.

HC-DFS1096

01-18
ET1

Employer

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

HC-DFS1594

01-21
ET

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

CERTIFICATE RIDER – Connecticut Residents

Rider Eligibility: Each Employee who is located in Connecticut

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

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

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

HC-ETCTDR

Important Information

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

Coupons, Incentives and Other Communications

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

HC-IMP265

08-19
V1 ET

Covered Expenses

Craniofacial Disorders

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

HC-COV1415

01-24
ET3



Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

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

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

HC-EXC554

01-24
ET3

Definitions

Dependent

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

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

HC-DFS1673

01-22
ET3

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 and dentures.

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 – 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

Covered Expenses

- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: a baseline mammogram for women ages 35 through 39; a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; a mammogram every year for women age 50 and over; and one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician's recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.
- charges made for diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint. Appliances and non-surgical treatment including for orthodontia are not covered.

- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.
- charges for general anesthesia and hospitalization services for dental procedures for an individual who is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.
- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.
- charges made for medical, surgical and Hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy. Services provided to you by a certified nurse-midwife or a licensed midwife, in a home setting or in a licensed birthing center. Coverage for a mother and her newborn child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. Post delivery care for a mother and her newborn shall be covered. Post delivery care includes: a postpartum assessment and newborn assessment, which can be provided at the hospital, the attending Physician's office, and outpatient maternity center or in the home by an Other Health Care Professional trained in mother and newborn care. The services may include physical assessment of the newborn and mother, and the performance of any clinical tests and immunizations in keeping with prevailing medical standards.
- charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: have vertebral abnormalities; are receiving long-term glucocorticoid (steroid) therapy; have primary hyperparathyroidism; have a family history of osteoporosis; and/or are estrogen-deficient individuals who are at clinical risk for osteoporosis.
- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be

Medically Necessary by the Physician and in consultation with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.

- charges for newborn and infant hearing screening as well as any Medically Necessary follow-up evaluations leading to diagnosis and subsequent Medically Necessary treatment of a diagnosed hearing impairment.
- charges for the coverage of child health supervision services from birth to age 16. Child health supervision services are physician-delivered or supervised services that include periodic visits which include a history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests.

HC-COV1498

01-25
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

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Exclusions, Expenses Not Covered and General Limitations

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

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

HC-EXC600

01-25
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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-TRM228

01-25
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Medical Benefits Extension Upon Policy Cancellation

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

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

Totally Disabled

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

- you are unable to perform the basic duties of your occupation; and



- you are not performing any other work or engaging in any other occupation for wage or profit.

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

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

HC-BEX42

04-11
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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 you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied, you can start the appeals procedure.

Prescription Drug Formulary Exception Appeals

Requests for an expedited review of coverage for a non-formulary alternative based on urgent circumstances must be determined and notice of the determination must be provided within 24 hours after all necessary information is received. Requests for other non-formulary alternative coverage reviews must be determined and notice of the determination provided within 72 hours after all necessary information is received.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a

denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Florida Adverse Determination Medical Necessity Appeal

To initiate an Adverse Determination appeal, you must submit a request in writing to Cigna within 30 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable to write, you may ask Cigna to assist so that you may register your written appeal. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form. Your appeal will be reviewed and the decision made by individuals not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by an Internal Panel of health care professionals. For appeals involving Medical Necessity or clinical appropriateness, the Internal Panel will include at least one Physician in the same or similar specialty as the care under consideration, as determined by the Cigna Physician reviewer. For Adverse Determination Medical Necessity Appeals, we will acknowledge in writing that we have received your request and schedule a panel review. For preservice and concurrent care coverage determinations, the panel review will be completed within 30 calendar days and for post service claims, the panel review will be completed within 60 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Internal Panel to complete the review. You will be notified in writing of the Internal Panel's decision within five working days after the panel considers your request.

Expedited Medical Necessity Appeal

You may request that the appeal process be expedited if: (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain



which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. The Cigna Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional. Please note that if you submit your written request within 30 days of receiving an initial denial notice, the Florida Adverse Determination Medical Necessity Appeal process described will apply. For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a post service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. If an issue does not qualify for the Expedited Medical Necessity Appeal process, you may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal. Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may present your situation to the Committee in person or by conference call. For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee

review will be completed within 15 calendar days. For post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage. If an issue does not qualify for the Expedited Medical Necessity Appeal process, you may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Appeal to the State of Florida

You have the right to contact the state regulators for assistance at any time. The state regulators may be contacted at the following addresses and telephone numbers:

The Statewide Provider and Subscriber Assistance Panel
Fort Knox Building One, Room 303
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456 or 850-921-5458
The Agency for Health Care Administration
Fort Knox Building One, Room 303
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456
The Department of Insurance
State Treasurer's Office
State Capitol, Plaza Level Eleven
Tallahassee, FL 32308
1-800-342-2762

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: availability, upon request, of the diagnosis and treatment codes and their meanings; the specific reason or reasons for the adverse determination including, if applicable the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific



plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit. You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two Appeal processes, the Florida Adverse Determination Medical Necessity Appeal process or the Expedited Medical Necessity Appeal process, as applicable. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

However, no action may be brought at all unless brought within three years after a claim is submitted for In-Network services, or within three years after proof of claim is required under the plan for Out-of-Network services.

HC-APL486

01-25
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Definitions

Dependent – For Medical Insurance

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided 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
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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
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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-COV1490

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You are entitled to a prompt and meaningful hearing for issues related to a denial, in whole or in part, of a health care service, treatment, or claim following exhaustion of all standard appeals requirements. The grievance hearing will be conducted by a panel of not less than 3 persons, including a Physician other than the medical director of the Plan, and a health care provider competent in the treatment or procedure which has been denied. You will be provided prompt notice in writing of the resolution. Immediate appropriate relief will be granted to you when the outcome is favorable to you. For adverse determinations, the notice will include specific findings related to the care, the policies, and procedures relied upon in making the determination, the Physician's and provider's recommendations, including any recommendations for alternative procedures or services, and a description of the procedures, if any, for reconsideration of the adverse decision.

Independent Review Procedure

Any external review procedure available under the plan will apply to any adverse determination regarding whether the plan complied with the surprise billing and cost sharing protections of the federal No Surprises Act and its implementing regulations.

If you are not fully satisfied with the decision of Cigna's level two appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant's rights to any other benefits under the Plan.

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When You Have A Complaint Or An Appeal

Step Therapy Override Appeals

Cigna will grant or deny a step therapy exception or appeal of a step therapy exception within:

- twenty-four hours in an urgent health care situation; and
- two business days from the date such request or appeal is submitted in a non-urgent health care situation.



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

CERTIFICATE RIDER – Idaho Residents

Rider Eligibility: Each Employee who is located in Idaho

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

HC-ETIDRDR

The Following Will Apply To Residents of Idaho 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.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services toll-free number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Cigna has a two step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required pre-service or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a post-service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.



Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or, clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may present your situation to the Committee in person or by conference call. For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review.

For required pre-service and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For post-service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding Medical Necessity, or if the level two appeal review was denied based upon a determination that it was investigational you or an authorized representative may request an Independent Review by submitting a written request to the Department of Insurance. You may also request an Independent Review if during the level two appeal process, you requested or agreed to a delay and have not received a written decision on the appeal within thirty-five (35) days following the date you filed the appeal, or you filed an appeal on an urgent care request on a pre-service or concurrent care

adverse benefit determination and have not received a determination within three (3) business days after filing, or Cigna has agreed to waive the exhaustion requirement.

An authorized representative is defined as a person to whom you have given express written consent to represent you in the Independent Review; a person authorized by law to provide substituted consent for you or your family member; or the/your treating health care professional only when you are unable to provide consent.

The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or based upon a determination that it was investigational by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Director of Insurance within four (4) months after the date of issuance of a notice of a final adverse benefit determination. The request shall be made on such form as may be designated by the Director. The assigned Independent Review Organization shall review all of the information and documents received and any other information submitted in writing to the Independent Review Organization.

The Independent Review Organization will render an opinion within 42 days.

You have the right to an expedited appeal if the request is an urgent care request.

If Cigna's Physician reviewer does not agree the appeal should be expedited, the Director may determine that a request is eligible for Independent Review, and require that it be referred for Independent Review. The review shall be completed within 72 hours.

The Independent Review Program is a voluntary program arranged by Cigna.



Assistance from the State of Idaho

The Director may be contacted at the following address and telephone number:

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd floor
P.O. Box 83720
Boise, ID 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two Appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action.

Your Right To An Independent External Review

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on the health carrier. You will have the right to further review of your claim by a court, arbitrator, mediator or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as more fully explained below under "Binding Nature of the External Review Decision."

If we issue a final adverse benefit determination of your request to provide or pay for a health care service or supply, you may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

The Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of your health care service or supply, or our determination your health care service or supply was investigational.

You must first exhaust our internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal, or unless you requested or agreed to a delay, our failure to respond to a standard appeal within 35 days in writing or to an urgent appeal within three business days of the date you filed your appeal. We may also agree to waive the exhaustion requirement for an external review request. You may file for an internal urgent appeal with us and for an expedited external review with the Idaho Department of Insurance at the same time if your request qualifies as an "urgent care request" defined below.

You may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3rd Floor
Boise, ID 83720-0043



For more information and for an external review request form: See the department's website at <http://www.doi.idaho.gov>, or call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without your completed authorization form.

If your request qualifies for external review, our final adverse benefit determination will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

Standard External Review Request: You must file your written external review request with the department within four months after the date we issue a final notice of denial.

1. Within seven days after the department receives your request, the department will send a copy to us.
2. Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
3. If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
4. Within seven days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

Expedited External Review Request: You may file a written "urgent care request" with the department for an expedited

external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

"Urgent care request" means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
2. In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of our intent to pay the covered benefit as soon as reasonably practicable, but not later than one business day after receiving notice of the decision.

Binding Nature of the External Review Decision: If your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on us. You may have additional review rights provided under federal ERISA laws.

If your plan is not subject to ERISA requirements, the external review decision by the independent review organization will be final and binding on both you and us. **This means that if you elect to request external review, you will be bound by**



the decision of the independent review organization. You will not have any further opportunity for review of our denial after the independent review organization issues its final decision. If you choose not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

HC-APL391

01-20
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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
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The Schedule

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

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

SCHEDIL-ETC

The Schedule

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

In-Network Diagnostic Related Services (i.e. "non-routine" services) for Mammograms will be covered at 100% without

application of any deductible, except if you're covered under a Qualified High Deductible Health Savings plan then the plan deductible will apply.

SCHED IL

ET-1

The Schedule

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

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

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

SCHED IL

ET-2

Certification Requirements - Out-of-Network For You and Your Dependents

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

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Covered Expenses

- charges for colorectal cancer screening prescribed by a Physician, and follow-up colonoscopies when a follow-up colonoscopy is determined by a health care provider to be Medically Necessary.
- charges for ambulatory surgical facilities and associated anesthesia charges for dental care that is provided to a covered individual who: is a child age 6 or under; has a medical condition that requires hospitalization or general anesthesia for dental care; or is disabled.

- charges made, and anesthetics provided by a dentist with a permit by the IL Department of Financial and Professional Regulation to administer general anesthesia, deep sedation, or conscious sedation in conjunction with care that is covered under this plan and provided to an insured in a dental office, oral surgeon's office, Hospital or ambulatory surgical treatment center if the individual is under age 26 and has been diagnosed with an Autism Spectrum Disorder or a Developmental Disability and has made 2 visits to the dental care provider prior to accessing this coverage.

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

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

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

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

- it is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
 - it is manifested before the individual reaches age 22;
 - it is likely to continue indefinitely; and
 - it results in substantial functional limitations in 3 or more of the following areas of major life activity: self-care, language, learning, mobility, self-direction, and capacity for independent living.
- charges made for or in connection with low-dose mammography screening including breast tomosynthesis for detecting the presence of breast cancer. Coverage shall include: a baseline mammogram for women ages 35 to 39; an annual mammogram for women age 40 and older; and mammograms at intervals considered Medically Necessary

for women less than age 40 who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors. Coverage also includes a comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches as well as a screening MRI when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches. Low dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device and image receptor, with radiation exposure delivery of less than one rad per breast for two views of an average sized breast. This term also includes digital mammography and includes breast tomosynthesis. The term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.

- charges made for the removal of breast implants when the removal of the implant is Medically Necessary treatment for a Sickness or Injury.
- charges made for complete and thorough clinical breast exams performed by a Physician licensed to practice medicine in all its branches, an advanced practice nurse who has a collaborative agreement with a collaborating Physician that authorizes breast examinations, or a Physician assistant who has been delegated authority to provide breast examinations. Coverage shall include such an exam at least once every three years for women ages 20 to 40; and annually for women 40 years of age or older.
- charges for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including, but not limited to the use of intravenous immunoglobulin 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 Care

Virtual Physician Services

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

HC-COV1457

01-23
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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
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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
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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
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Definitions

Dependent – For Vision Benefits

Dependents include:

- your lawful spouse, including your civil union partner (The Religious Freedom Protection Act and Civil Union Act, 750 ILCS 75, allows both same-sex and different-sex couples to



enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples).

HC-DFS799

07-15
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Kansas Residents

Rider Eligibility: Each Employee who is located in Kansas

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

HC-ETKSRDR

Important Notice

This notice is to advise you that Cigna will, upon request, provide you with the following:

- a complete description of health care services; a description of limitations and exclusions; prior authorization policies; restricted drug formularies; other provisions restricting access; a copy of the participating provider directory; notice of plan changes that affect benefits or cost; a description of the available grievance and appeal procedures; and description of your rights regarding termination, disenrollment, nonrenewal, or cancellation of coverage.
- the right to request an independent external review of an adverse decision by the plan when the covered person has exhausted all internal review procedures for nonemergency medical conditions, the covered person has not received a

final decision within 60 days of seeking the internal review and did not request the delay, or there is an emergency medical condition. Within 90 days receipt of the adverse decision, the request for external review must be sent in writing to the Commissioner from the covered person, his treating Physician with written authorization, or a legally authorized designee of the covered person. The covered person must provide all pertinent information, an appeal form, and a fully executed release form pertaining to medical records. Upon request from the Commissioner, the covered person or insurer/HMO must provide pertinent information within five business days. The Commissioner will negotiate contracts with external review organizations, allow the participants to provide additional written information, make a decision on the request within ten business days of receiving all necessary information, and notify the covered person, provider or designee in writing if the request for external review was granted. The external review organization chosen by the Commissioner will issue a binding written decision to the covered person, insurer and Commissioner within 30 business days, expedited resolution when an emergency condition exists within seven business days.

HC-IMP42

04-10
V1-ET

Eligibility - Effective Date

Late Entrant - Employee

You are a Late Entrant if:

- 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).

You are not a Late Entrant if you did not elect coverage under this plan when you were first eligible to do so because:

- you were covered under another group plan; and
- you stated in writing when you declined this plan's coverage that the other coverage was the reason for declining coverage under this plan; and
- you lose coverage under the other group plan as a result of termination of employment, reduction in the number of employment hours, termination of employer contributions toward that coverage; the other plan terminates; death of a spouse or divorce or legal separation; or expiration of any continued coverage period under that plan; and

- you elect coverage under this plan no later than 30 days after termination of the other plan coverage.

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).
- you are not a Late Entrant for Dependent Insurance if you did not elect coverage under this plan for an eligible Dependent when you were first eligible to do so, but are later required by court order to cover the Dependent under this plan.
- you are not a Late Entrant for Dependent Insurance if you did not elect coverage under this plan for an eligible Dependent because:
 - the Dependent was covered under another group plan; and
 - you stated in writing when you declined this plan's coverage that the other coverage was the reason for declining coverage under this plan for the Dependent; and
 - the Dependent loses coverage under the other group plan as a result of termination of employment, reduction in the number of employment hours, termination of employer contributions toward that coverage; the other plan terminates; death of a spouse or divorce or legal separation; or expiration of any continued coverage period under that plan; and
 - you elect coverage under this plan for the Dependent no later than 30 days after termination of the other plan coverage.

HC-ELG406

01-24
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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 per person however, the 3 visit limit will not apply to treatment of diabetes.”

SCHEDDENE-ET1

Covered Expenses

- charges for a prostate-specific antigen (PSA) blood test and a digital rectal examination for a male aged 50 and over regardless of whether or not symptoms are present; and a male aged 40 or over who is symptomatic or who is considered a high risk for prostate cancer.

Autism Spectrum Disorders

- charges made for all generally recognized services prescribed in relation to Autism Spectrum Disorder for Dependent children. Such coverage must be prescribed by a Physician, in a treatment plan and shall include evaluation and assessment services; applied behavior analysis; speech therapy; occupational therapy; and physical therapy.
- Autism Spectrum Disorder 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.
- charges incurred at birth for the delivery and obstetrical expenses of or for the birth mother of a child who is legally adopted by you within 90 days from date of birth, if you choose to file a claim for such expenses, subject to all other terms of these Medical Benefits.
- charges made for immunizations for a Dependent child from birth to age 6 for: not fewer than 5 doses of vaccine each for diphtheria, pertussis, tetanus; 4 doses polio, Haemophilus influenzae type b; 3 doses Hepatitis B; at least one dose of vaccine each for measles, mumps, rubella, and chicken pox; other vaccines and dosages as prescribed by the secretary of health and environment; and office visit expenses, or equivalent expenses, when incurred while obtaining such vaccinations.
- charges made for Papanicolaou laboratory screening tests, including services performed at a certified mobile facility.
- charges for a drug that has been prescribed for the treatment of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration if that drug has been recognized as a treatment for cancer in one of the standard reference compendia or supported by articles in accepted, peer-reviewed medical literature. Coverage will also be provided for any medical services necessary to administer the drug.
- charges for diagnosis and treatment of mental illnesses and alcoholism, drug abuse or other substance use disorders. Mental illness, alcoholism, drug abuse or substance use means any disorder as such terms are defined in the Diagnostic and Statistical Manual of Mental Disorders

(DSM-IV, 1994). Coverage is subject to the limits outlined in The Schedule.

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 Supplies:
 - blood glucose monitors, including those designed to be used by the legally blind;
 - 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;
 - injection aids, including devices used to assist with insulin injection and needleless systems;
 - insulin syringes;
 - insulin pumps, and accessories;
 - glucagon emergency kits;
 - diabetes outpatient self-management training and education provided by a certified, registered or licensed health care professional with expertise in diabetes if ordered by a professional legally authorized to prescribe such services and the diabetic is treated: at a program approved by the American Diabetes Association; by a person certified by: the National Certification Board for Diabetes Educators; or by a licensed dietitian pursuant to a treatment plan authorized by such health care professional; and
 - medical nutritional therapy and education.

Mammograms

Charges made for mammograms including services up to and including tomosynthesis, or 3D mammography when performed at the direction of a person licensed to practice medicine and surgery by the board of healing arts within the lawful scope of such person's license, including services performed at a mobile facility certified by the federal health care financing administration and performing mammography testing by American Cancer Society guidelines.

Mental Health and Substance Use Disorder Services

Mental Health Services are services that are required to treat a mental illness as specified in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American Psychiatric Association. 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 according to the diagnostic and statistical manual of mental disorders, fourth edition (DSM-IV, 1994) of the American Psychiatric Association as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Use Disorder.

Inpatient Mental Health Services

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

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

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

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

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Partial Hospitalization or Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or

concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

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

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

Inpatient Substance Use Disorder Rehabilitation Services

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

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

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

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

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

Outpatient Substance Use Disorder Rehabilitation Services

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

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

A Substance Use Disorder Intensive Outpatient Therapy Program consists of treatment that is 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-COV498

10-15
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Medical Pharmaceuticals

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

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

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

The Cigna Business Decision Team determines whether utilization management requirements or other coverage conditions should apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. When considering a Medical Pharmaceutical for a coverage status, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a

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

HC-COV573

10-16
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The Schedule

The pharmacy Schedule is amended to indicate the following:

Oral Chemotherapy Medication

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

SCHEDPHARM90-kset

Prescription Drug Benefits

Covered Expenses

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

Coverage under your plan's Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure. Additionally, the plan shall provide coverage for psychotherapeutic Prescription Drug Products used for the treatment of mental illness on a basis no less favorable than coverage provided for other Prescription Drug Products.

HC-PHR511

01-24
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Termination of Insurance

Special Continuation of Medical Insurance

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

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

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

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

Dependent Medical Insurance after Divorce

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

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

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

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

Conversion Available Following Continuation

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

HC-TRM42

04-10
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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 Confined in a Hospital 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 no longer Confined in a Hospital; or
- 31 days has passed since the date the policy is canceled.

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

HC-BEX68

01-24
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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.

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service toll-free number that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Cigna has a one-step appeal procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law,



continued coverage pending the outcome of an appeal. Appeals may be submitted, to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

We will respond in writing with a decision within 30 calendar days after we receive an appeal for a required preservice determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services or if the service has been determined experimental or investigational and the treating Physician certifies in writing, that the recommended or requested health care service or treatment for the medical condition would be significantly less effective if not promptly initiated.

If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level one appeal would be detrimental to your medical condition.

Cigna's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent External Review Procedure

If you are not fully satisfied with the decision of Cigna's appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent External Review Organization. The Independent External Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to use the voluntary external level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent external review process. Cigna will abide by the decision of the Independent External Review Organization.

In order to request a referral to an Independent External Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. You may also request an external review if you have not received a final decision within 60 days of seeking an internal appeal review.

To request a review, you must notify the Kansas Commissioner of Insurance within 120 days of your receipt of Cigna's appeal review denial. Once the Commissioner has approved your request for external review, Cigna will forward the file to the selected Independent External Review Organization.

The Independent External Review Organization will render an opinion within 30 days. When a delay would be detrimental to your condition, you may request an expedited external review. If approved, the Independent External Review Organization shall complete the review not more than 72 hours after the date of receipt of the request for an expedited external review or as expeditiously as the medical condition or circumstances require.

Assistance from the State of Kansas

You have the right to contact the Kansas Insurance Department for assistance at any time. The Kansas Insurance Department may be contacted at the following address and telephone number:

Kansas Insurance Department
1300 Arrowhead Rd.
Topeka, KS 66604
Toll Free Number: 1-800-432-2484

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the

specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action in federal court under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna in federal court until you have completed the appeals processes. In all events, such suit or proceeding must be commenced no later than five (5) years after the date from the time written proof of loss is required to be given.

HC-APL373

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The Schedule

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

Elective Abortion

Abortion means the use or prescription of any instrument, medicine, drug or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma or a criminal assault on the pregnant woman or her unborn child and which causes the premature termination of the pregnancy.

Elective means an abortion for any reason other than to prevent the death of the mother upon whom the abortion is performed; provided, that an abortion may not be deemed one to prevent the death of the mother based on a claim or diagnosis that she will engage in conduct which will result in her death.

HC-RDR37

04-10

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Definitions

Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can,



under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the plan, this definition also includes:

- The following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips, diabetic pharmaceutical supplies;
- Needles and syringes for self-administered medications or Biologics covered under the plan's Prescription Drug benefit; and
- Inhaler assistance devices and accessories, peak flow meters.

This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

HC-DFS1009

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Review Organization

The term Review Organization means any entity which conducts utilization review and determines certification of an admission, extension of stay or other health care service.

HC-DFS808

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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, 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.

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.

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

Covered Expenses

- charges for cochlear implants for persons age 2 and over with the diagnosis of profound sensorineural deafness or postlingual deafness in adults. Cochlear implants for children under age 2 will be covered when, upon review, they are determined to be Medically Necessary.
- charges for the necessary care and treatment of medically diagnosed inherited metabolic diseases. Coverage must include amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases provided that the amino acid products are prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic diseases, and are administered under the direction of a Physician.
- 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 for tobacco cessation services recommended by the U.S. Preventive Services Task Force, including but not limited to individual, group, and telephone counseling, and any combination thereof.
- charges for hearing aids and all related services for persons under 18 years of age when prescribed by licensed audiologists and dispensed by an audiologist or hearing instrument specialist. Coverage will be limited to the full cost of one hearing aid per hearing impaired ear every 36 months. Coverage includes 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.

- The following benefits will apply to insulin and noninsulin-dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:
 - charges for Durable Medical Equipment, including podiatric appliances, related to diabetes. A special maximum will not apply.
 - charges for insulin; syringes; prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips; urine test strips; lancets; and alcohol swabs.
 - charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
 - Medically Necessary visits when diabetes is diagnosed;
 - visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
 - visits when reeducation or refresher training is prescribed by the Physician; and
 - Medical Nutrition therapy related to diabetes management.
 - charges for colorectal cancer screening examinations and 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.

Genetic Testing for Cancer Risk

Charges for 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.

Charges for any genetic test for cancer risk that is recommended by any of the following:

- if the recommendation is consistent with the most recent version of genetic testing guidelines published by the National Comprehensive Cancer Network (NCCN);
- a Physician, Physician assistant, or genetic counselor licensed under KRS Chapter 311; or
- an advanced practice registered Nurse licensed under KRS Chapter 314.

Telehealth

Dedicated Telehealth Providers

Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as

medically 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 but not limited to 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 but not limited to 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.

Enteral Nutrition

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

Coverage includes 100% human milk fortifiers for prevention of Necrotizing Enterocolitis.

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).

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 covered or could not be covered by another group plan (insured or uninsured) or you are not covered by substantially similar benefits by an individual insurance policy.
- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- your insurance ceased, unless you performed an act or practice that constitutes fraud in connection with the coverage; or made an intentional misrepresentation of a material fact under the terms of the coverage.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

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

Overinsured

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

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

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

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

Converted Policy

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

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

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

The Schedule

Oral Chemotherapy Medication

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



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

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

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Prescription Drug Benefits

Limitations

Prescription Eye Drops

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

Supply Limit Exceptions

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

Your Payments

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

- consumable medical supplies other than ostomy supplies and urinary catheters. Examples are: 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.

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

CERTIFICATE RIDER – Louisiana Residents

Rider Eligibility: Each Employee who is located in Louisiana

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 Louisiana group insurance plans covering insureds located in Louisiana. 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 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-IMP298

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The Schedule

The Schedule of your medical certificate is hereby changed to indicate the following:

Preventive Care Related Services (i.e. “routine” services) for “Mammograms and Digital Breast Tomosynthesis” and “PAP

Smear” will be covered at 100%/No charge In-Network and plan coinsurance Out-of-Network. These benefits are not subject to any plan deductible.

Diagnostic Related Services (i.e. “non-routine” services) for “Mammograms and Digital Breast Tomosynthesis” and “PAP Smear” will be covered at plan coinsurance In-Network and Out-of-Network. These benefits are not subject to any plan deductible, unless you are enrolled in a Health Savings Plan or Qualified High Deductible Health Plan.

SCHEDLA-laetc

The Schedule

The provision “Maternity Care Services” in your medical schedule is amended to indicate the following:

The note regarding “OB/GYN providers” is amended to read as follows:

Note:

OB/GYN, Doula or Midwife providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna on an In-Network basis. Out-of-Network OB/GYN, Doula or Midwife providers will be considered a Specialist.

The following note regarding “Maternity Care Services” is hereby added:

Note:

Maternity Care Services provided by a Doula are limited to \$1,500 per pregnancy.

The sub-heading regarding “All subsequent Prenatal/Postnatal Visits” is amended to read as follows:

All subsequent Prenatal Visits, Postnatal Visits and Physician’s/Doula’s/Midwife’s Delivery Charges (i.e. global maternity fee)

The sub-heading regarding “Physician’s Office Visits in addition to the global maternity fee” is amended to read as follows:

Physician’s Office Visits in addition to the global maternity fee when performed by an OB/GYN, Doula, Midwife or Specialist

SCHEDLA-laet1c

Covered Expenses

- coverage for COVID-19 diagnostic tests, antibody tests, and antiviral drugs in accordance with the cost-sharing and duration requirements of Section 3201 of the CARES Act and section 6001 of the FFCRA.
- charges for Medically Necessary drugs, prescribed by a Physician, for the treatment of metastatic or unresectable tumors or other advanced cancers. Coverage for such Medically Necessary drugs will not be denied for treatment of a metastatic, unresectable tumor, or other advanced cancers on the basis that the drug is not indicated for the specific tumor type or location of cancer in the patient's body if the drug is approved by the FDA for the treatment of the specific mutation in a different type of cancer.
- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to charges made for cancer screening in connection with bilateral mastectomy, including genetic screening tests. Any health coverage plan which is delivered or issued for delivery in this state shall include benefits payable for minimum mammography examination, including but not limited to digital breast tomosynthesis and a Diagnostic Imaging. Minimum mammography examination means mammography examinations performed no less frequently than the following schedule provides:
 - one baseline mammogram for any woman who is 35 through 39 years of age.
 - one mammogram annually for women over the age of 40.
 - consideration given to supplemental imaging if recommended by her Physician, for women with increased breast density (C and D density). This includes a breast ultrasound as the initial preferred modality, followed by an MRI if inconclusive.
 - access to annual supplemental imaging for women with a prior history of breast cancer below the age of 50, or with a prior history of breast cancer at any age and dense breast (C and D density).
 - annual mammogram (DBT preferred modality) and access to supplemental imaging (MRI preferred modality) starting at age 35 if recommended by her Physician that she has a predicted lifetime risk greater than 20% by any validated model published in peer reviewed medical literature; and
 - women with a hereditary susceptibility from pathogenic mutation carrier status, or prior chest wall radiation, must receive coverage for an annual MRI starting at age 25, and annual mammogram at 30. These examinations have to be in accordance with recommendations by the

National Comprehensive Cancer Network guidelines or the American Society of Breast Surgeons Position Statement on Screening Mammography.

- charges for treatment of severe mental illness, on the same basis as other Sickness covered under the plan. "Severe mental illness" includes:
 - schizophrenia or schizoaffective disorder;
 - bipolar disorder;
 - panic disorder;
 - obsessive-compulsive disorder;
 - major depressive disorder;
 - anorexia/bulimia;
 - intermittent explosive disorder;
 - post-traumatic stress disorder;
 - psychosis NOS (not otherwise specified) when diagnosed in a child under age 17;
 - Rett's Disorder; and
 - Tourette's Disorder.

Autism Spectrum Disorder

- charges for the diagnosis and treatment of Autism Spectrum Disorders, including applied behavioral analysis. Such coverage shall include the following care prescribed, provided or ordered by a Physician or a Psychologist who is licensed in this state who shall supervise provision of such care:
 - Medically Necessary assessments, evaluations, or tests to diagnose an Autism Spectrum Disorder;
 - habilitative or rehabilitative care;
 - pharmacy care;
 - psychiatric care;
 - psychological care; and
 - therapeutic care.

Autism Spectrum Disorders include any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including Autistic Disorder, Asperger's Disorder and Pervasive Developmental Disorder – Not Otherwise Specified. Benefits for the diagnosis and treatment of Autism Spectrum Disorders are payable on the same basis as any other Sickness covered under the plan.

Biomarker Testing

Charges for biomarker testing when it is done for the purpose of guiding treatment decisions for the ongoing monitoring of a member's disease or condition, when the test provides clinical

utility as demonstrated by medical and scientific evidence, including, but not limited to:

- labeled indications for diagnostic tests or drugs cleared by the FDA.
- warnings and precautions listed on an FDA approved drug label.
- National Coverage Determinations of CMS, or local Coverage Determinations of Medicare Administrative Contractors.
- nationally recognized clinical practice guidelines.

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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 the insurance company 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 use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, invasive/non-invasive 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.

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Short-Term Rehabilitative Therapy

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- sensory integration therapy, group therapy; treatment of dyslexia;
- behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional speech disorders such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.

Multiple outpatient services provided on the same day constitute one day.

Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes 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. For these

services you have direct access to qualified chiropractic Physicians.

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law.

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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.
- any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:
 - the study or investigation has been reviewed and approved through a system of peer review comparable to

the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and

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

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

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

Examples of routine patient care costs and services include:

- radiological services.
- laboratory services.
- intravenous therapy.
- anesthesia services.
- Physician services.
- office services.
- Hospital services.

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

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

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

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The Schedule

The pharmacy Schedule is amended to indicate the following:

Oral Chemotherapy Medication

Prescription oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered at participating pharmacies at 100% after deductible, if applicable and if applicable at non-participating pharmacies, on a basis no less favorable than the out of network medical cost share for injectable/IV chemotherapy.

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Prescription Drug Benefits

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule. Coverage includes charges for Medically Necessary drugs, prescribed by a Physician, for the treatment of metastatic or unresectable tumors or other advanced cancers. Coverage for such Medically Necessary drugs will not be denied for treatment of a metastatic, unresectable tumor, or other advanced cancers on the basis that the drug is not indicated for the specific tumor type or location of cancer in the patient's body if the drug is approved by the FDA for the treatment of the specific mutation in a different type of cancer. Your benefits may vary depending on which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

Modifications to drug coverage under a health plan may be made only if the modification occurs at time of coverage

renewal. You will be notified of any of the following modifications to the Prescription Drug List:

- removing a drug from the formulary;
- adding a requirement that an enrollee receive prior authorization for a drug;
- imposing or altering a quantity limit for a drug; and
- moving a drug to a higher cost sharing tier (unless a generic drug alternative to the drug is available).

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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. 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.

When medications for the treatment of any medical condition are restricted for use by a step therapy or fail first protocol, the prescribing Physician shall have access to a clear and convenient process to expeditiously request an override of such restriction from the insurer. An override shall be granted for the following circumstances:

- the prescribing Physician can demonstrate that the preferred treatment required under step therapy or fail first protocol has been ineffective in the treatment of the medical condition.
- the prescribing Physician can demonstrate that the preferred treatment required under the step therapy or fail first protocol is reasonably expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the insured and known characteristics of the drug regimen.
- the prescribing Physician can demonstrate that the preferred treatment required under the step therapy or fail first protocol will cause or will likely cause an adverse reaction or other physical harm to the insured.

The duration of any step therapy protocol shall not be longer than the customary period for the medication when such treatment is demonstrated by the prescribing Physician to be clinically ineffective. When the plan can demonstrate that the originally prescribed medication is likely to require more than

the customary period for the medication to provide any relief or an amelioration to the insured, the step therapy or fail first protocol may be extended for an additional period of time no longer than the original customary period for the medication.

No plan shall use step therapy or fail first protocols as the basis to restrict any prescription benefit for the treatment of stage-four advanced, metastatic cancer or associated conditions if at least one of the following criteria is met:

- the prescribed drug or drug regimen has the United States Food and Drug Administration approved indication.
- the prescribed drug or drug regimen has the National Comprehensive Cancer Network Drugs and Biologics Compendium indication.
- the prescribed drug or drug regimen is supported by peer-reviewed, evidenced-based medical literature.

These provisions will apply if the preferred drug or regimen is considered clinically equivalent for therapy, contains the identical active ingredient or ingredients, and is proven to have the same efficacy.

For drugs prescribed for associated conditions, the treating healthcare provider shall inform the plan that the condition is one associated with stage-four advanced, metastatic cancer when requesting authorization.

A determination for an override request will be rendered within 72 hours for a standard request, and 24 hours for an urgent request. If the plan fails to comply with the timelines, the override request shall be considered approved.

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.

When coverage is provided for topical ophthalmic prescriptions, coverage for an early refill of the topical ophthalmic prescription will be permitted if you make the request:

For a 30 day supply, between 23 and 30 days from the later of either:

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

For a 60 day supply, between 46 and 60 days from the later of either:

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

For a 90 day supply, between 69 and 90 days from the later of either:

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

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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 will always be the lowest of:

- the Copayment or Coinsurance 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.

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- 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. (This exclusion will not apply to benefits for services rendered by a medical facility owned or operated by the state of Louisiana or any of its political subdivisions.)

If the following text "Provided further,....or any of its political subdivisions." 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 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. (This exclusion will not apply to benefits for services rendered by a medical facility owned or operated by the state of Louisiana or any of its political subdivisions.)

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 the authoritative compendia as identified by the secretary of the United States Department of Health and Human Services or in accepted peer-reviewed medical literature.

- for charges which would not have been made if the person did not have coverage. (This exclusion will not apply to benefits for services rendered by a medical facility owned or operated by the state of Louisiana or any of its political subdivisions.)
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- for expenses for services, supplies, care, treatment, drugs, or surgery that are not Medically Necessary.
- for charges made by any Physician or Other Health Professional who is a member of your family or your Dependent's family.
- for expenses incurred outside the United States other than expenses for Medically Necessary emergency or urgent care while temporarily traveling abroad.

Termination of Insurance

Continuation

Medical Insurance for Surviving Spouse

For purposes of this section, the term Surviving Spouse means your legal spouse who at the time of your death is:

- 50 or more years old; and
- insured as your Dependent for Medical Insurance.

If you die while insured for Medical Insurance, your Surviving Spouse may continue to be insured for such benefits subject to the terms set forth below.

Your Employer will notify your Surviving Spouse of his right to elect continuation of his Medical Insurance. Your Surviving Spouse, within 90 days of the date the insurance would otherwise cease, may elect such continuation in writing and by paying the required premium to your Employer. If your Surviving Spouse elects this option, his insurance will be continued until he:

- becomes eligible for another group medical plan;
- becomes eligible for Medicare;
- remarries; or
- discontinues premium payments to your Employer;

whichever occurs first.

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

Continuation of Medical Insurance during Active Military Duty

If your coverage would otherwise cease because you are a Reservist in the United States Armed Forces and are called to active duty, the insurance for you and your Dependents will be continued during your active duty only if you elect it in writing, and will continue until the earliest of the following dates:

- 90 days from the date your military service ends;
- the last day for which you made any required contribution for the insurance; or
- the date the group policy cancels.

Additionally, a Dependent who is called to active duty will not cease to qualify for Dependent coverage due to his/her active duty status if he or she has elected to continue coverage in writing. Coverage will be continued for that Dependent during his or her active duty until the earliest of the following dates:

- the date insurance ceases.
- the last day for which the Dependent has made any required contribution for the insurance;



- the date the Dependent no longer qualifies as a Dependent; or
- the date Dependent Insurance is canceled.

Reinstatement of Medical Insurance

If your coverage ceases because you are a Reservist in the United States Armed Forces and are called to active duty, the insurance for you and your Dependents will be automatically reinstated after your deactivation, provided that you return to Active Service within 90 days.

If coverage for your Dependent has ceased because he or she was called to active duty, the insurance for that Dependent will be automatically reinstated after his or her deactivation, provided that he or she otherwise continues to qualify for coverage.

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 any condition that you or your Dependent developed while coverage was interrupted. The remainder of a Pre-existing Condition Limitation which existed prior to interruption of coverage may still be applied.

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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.

Start With Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your

concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted, to the following address:

Cigna HealthCare Inc.
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

If Cigna fails to strictly adhere to all the requirements of the internal claims and appeals process, you may initiate an external Independent Review and/or pursue any available remedies under applicable law.

Level-One Appeal

Your appeal will be reviewed and the decision will be made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services.

If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same



time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level-Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To start a level-two appeal, follow the same process required for a level-one appeal.

Requests for a level-two appeal regarding the Medical Necessity or clinical appropriateness of your issue will be conducted by a Committee, which consists of one or more people not previously involved in the prior decision. The Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level-two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the Committee's decision within 5 working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an

expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on Medical Necessity, appropriateness, health care setting, level of care, effectiveness, experimental or investigational treatment or rescission as determined by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level-two appeal review denial. Cigna will then forward the file to the Independent Review Organization that has been assigned to your case by the Louisiana Department of Insurance (LA DOI).

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by Cigna's Physician reviewer, the review shall be completed within 3 days.

The Independent Review Program is a voluntary program arranged by Cigna.

Assistance from the State of Louisiana

You have the right to contact the Louisiana Department of Insurance for assistance at any time. The Louisiana Department of Insurance may be contacted at the following address and telephone number:

Louisiana Department of Insurance
1702 N. 3rd Street
Baton Rouge, LA 70802
800-259-5300 (toll free within Louisiana)
225-342-5900

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

An adverse determination means any of the following:

- A determination that a request for a benefit under the HII's plan does not meet the HII's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.
- The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a HII (or a URO) of a covered person's eligibility to participate in the health insurance issuer's health benefit plan.
- Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit under a health benefit plan.
- A rescission of coverage determination.

(Rescission defined as cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage).

- Initial eligibility for coverage determinations are reviewable. (Denials of eligibility).

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level-one and level-two appeal processes. If your Appeal is expedited, there is no need to complete the level-two process prior to bringing legal action.

HC-APL403

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Definitions

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
 - less than 26 years old.
 - your eligible Dependent as determined under the terms of the Employer's plan and reported by the Employer to Cigna. An eligible Dependent include spouse, children under 26 years of age, and grandchildren under 26 years of age who are in the legal custody of and residing with the grandparent.
 - 26 or more years old, 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 the first two years following the child's attainment of the limiting age, 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 under the age of 26 who is legally adopted by you, including a child who is placed in your home according to an adoption Placement agreement executed with a licensed adoption agency effective from the date of Placement in your home, or any child, following execution of an act of voluntary surrender in favor of you or your legal representative effective from the date on which the act of voluntary surrender becomes irrevocable. It also includes:

- a stepchild;
- any grandchild of yours provided such child is under 26 years of age, or in the case of full-time students, under years of age, and is in your legal custody;
- any grandchild of yours who is in your legal custody, and is incapable of self-sustaining employment by reason of intellectual or physical disability which existed prior to the child's 26th birthday.

If your Domestic Partner has a child that lives with you, 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 spouse. 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.

midwifery care, to pregnant and birthing women and their families before, during, and after childbirth.

HC-DFS1886

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Emergency Medical Condition

A Medical Condition, including a mental health condition or substance use disorder, of recent onset and severity, including severe pain that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in: (a) 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; (b) Serious impairment to bodily function; or (c) Serious dysfunction of any bodily organ or part.

HC-DFS1863

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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.

HC-DFS1864

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HC-DFS1720

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Doula

An individual who has been trained to provide physical, emotional, and educational support, but not medical or



Creditable Coverage

The term Creditable Coverage means coverage of an individual under: a group health plan; Health insurance coverage; Medicare coverage; Medicaid; Medical insurance coverage under the General Military Law; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered for federal employees; a public health plan; or a health benefit plan provided to members of the Peace Corps. Such term does not include coverage consisting solely of excepted benefits.

HC-DFS422

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

CERTIFICATE RIDER – Maine Residents

Rider Eligibility: Each Employee who is located in Maine

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

HC-ETMERDR

Important Notices

Important Notice Regarding Cancellation of Coverage

This notice is to advise you that you have the right to designate a third party to receive notice of cancellation of your coverage under this plan.

Designation of Third Party to Receive Notice

If you would like to designate a third party to receive notice of cancellation of your coverage, you can call Member Services at 1-800-244-6224 or the phone number shown on your ID card. Member Services will send to you a "Third Party Notice Request Form," which you should complete and return to your Employer or Plan Administrator, as appropriate.

You also have the right to change the person or party you have designated to receive notice of cancellation of your coverage. A request to change designation should be made in writing to your Employer or Third-Party Administrator.

Right to Reinstatement for Insureds with Cognitive Impairment or Functional Incapacity

Should your coverage be cancelled, you have the right to have your coverage reinstated if:

- you suffer from cognitive impairment or functional incapacity; and
- the reason your coverage cancelled was because you did not pay your premium or because of another lapse or default on your part.

Notice Regarding Comparable Health Care Services

You have the ability to obtain estimated costs for any "Comparable Health Care Services" based on a description of the service or the applicable standard medical codes or current procedural codes used by the American Medical Association. This is available by visiting www.myCigna.com or calling the toll-free number on your ID card. Comparable Health Care Services are: (1) Physical and Occupational Therapy services; (2) Radiology and imaging services; (3) Laboratory services; and (4) Infusion therapy services.

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

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

Eligibility - Effective Date

Waiting Period

The provision in your certificate, if any, entitled "Waiting Period" will not exceed 30 days for Maine residents.

Dependent Insurance

Exception for Newborn Grandchildren

Any child born to your Dependent child while you are insured for Medical Insurance 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.

The Schedule

If your medical schedule includes an "Out-of-Network Emergency Services Charges" provision, it is amended to add the following text:

Out-of-Network Emergency Services Charges

Emergency Ambulance Services are covered at the In-Network cost-sharing level if services are received from a non-Participating (Out-of-Network) Provider.

An Emergency Services provider may request dispute resolution pursuant to a Maine law, if the provider and Cigna cannot agree on an allowable amount.

SCHEDME-ET

Covered Expenses

- charges made for a colorectal cancer screening for asymptomatic persons who are 50 years of age or older, or less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society.
- abortion services.
- charges for anesthesia services and Hospital and facility services related to dental procedures, in order to safely and effectively perform the dental procedures if the insured: is exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia (with or without additional adjunctive techniques and modalities) cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result; is demonstrating dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy; is an extremely uncooperative, fearful, anxious or uncommunicative child or adolescent with dental needs of such magnitude that treatment should not be postponed or deferred, and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity; and has sustained extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
- charges made for hearing aids and associated exam for device testing and fitting, 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 and delivers speech and other sounds at levels equivalent to that of normal speech and conversations.
- charges made for treatment, including Day Treatment, of mental or nervous conditions that are caused by biological disorders, which includes: psychotic disorders, including schizophrenia; dissociative disorders; mood disorders; anxiety disorders; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental disorders; tic disorders; eating disorders, including bulimia and anorexia; and substance abuse-related disorders. The treatment of these illnesses is covered at the same level as other medical conditions. All other mental health services are covered subject to the Copayments and limitations as outlined in The Schedule.
- charges for inpatient coverage with respect to the treatment of breast cancer, for a period of time determined by the attending Physician, in consultation with you, to be

medically appropriate following a mastectomy, lumpectomy or lymph node dissection for the treatment of breast cancer.

- charges for diabetic equipment and outpatient diabetic training through ambulatory diabetes training facilities authorized by the State's Diabetes Control Projects within the Bureau of Health.
- charges for a drug prescribed for the treatment of cancer for a medically accepted indication, even if the drug has not been approved by the federal Food and Drug Administration for that indication. However, use of the drug must be a medically accepted indication for the treatment of cancer, in general. "Medically accepted indication" means another use of the drug if that use is supported by one or more citations in the standard reference compendia (the United States Pharmacopeia Drug Information or the American Hospital Formulary Service Drug Information) or the Plan, based on guidance from the federal Medicare program, determines such use is medically accepted based on supportive clinical evidence in peer-reviewed medical literature. Coverage includes Medically Necessary services given in connection with the administration of the drug.
- charges for a drug prescribed for the treatment of HIV or AIDS, even if the drug has not been approved by the federal Food and Drug Administration for that indication, as long as the drug is recognized for the treatment of that indication in one of the standard reference compendia (the United States Pharmacopeia Drug Information or the American Hospital Formulary Service Drug Information) or in peer-reviewed medical literature. Coverage includes Medically Necessary services given in connection with the administration of the drug.
- charges for laboratory testing expenses will be covered in full when recommended by a Physician for ongoing monitoring of HIV prevention drug treatment.
- charges for treatment of autism spectrum disorders including physical, occupational and speech therapy and Applied Behavior Analysis (ABA) when determined by a licensed Physician or licensed Psychologist to be Medically Necessary. (The licensed Physician or licensed Psychologist may be required to demonstrate ongoing Medical Necessity, at least annually, for continued coverage of such treatment.) Coverage includes any assessments, evaluations or tests by a licensed Physician or licensed Psychologist to diagnose an autism spectrum disorder.
- charges for Children's Early Intervention Services. Children's Early Intervention Services are services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified development Disability or delay such as

intellectual disabilities, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities.

- charges for routine newborn care required by state law are part of the mother's benefit. The mother and the newborn are treated as one person in calculating the Deductible, Coinsurance and Copayments for coverage.
- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage on oral contraceptives.
- charges for laboratory fees up to \$150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability.

Postpartum Care

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

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

Enteral Nutrition

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

Charges for metabolic formulas and special modified low-protein food products, when prescribed by a Physician, for a person with an inborn error of metabolism (e.g. disorders of amino acid or organic acid metabolism). Low protein food products do not include foods naturally low in protein. Coverage also includes charges for amino acid-based elemental infant formula for children two years of age and under, without regard to the method of delivery of the formula, when: a Physician has submitted documentation that the amino acid-based elemental infant formula is Medically Necessary; the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater; and other commercial infant formulas, including cow milk-based and soy milk-based formulas, have been tried

and have failed or are contraindicated. Coverage for amino acid-based elemental infant formula must be provided when a licensed Physician has diagnosed and through medical evaluation has documented one of the following conditions: symptomatic allergic colitis or proctitis; laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis; a history of anaphylaxis; gastroesophageal reflux disease that is nonresponsive to standard medical therapies; severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider; cystic fibrosis; or malabsorption of cow milk-based or soy milk-based infant formula.

Hospice Care Services

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

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

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

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

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

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

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

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for repair or replacement of a prosthetic device if repair or replacement is determined appropriate by your provider.

External prosthetic appliances and devices include prostheses/prosthetic appliances and devices; orthoses and orthotic devices; braces; and splints.

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

Medical Conversion Privilege

The provision in your certificate, if any, entitled "Medical Conversion Privilege" will not apply to Maine residents.

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.

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Prescription Drug Benefits

Covered Expenses

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

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

Formulary Exception Process

1. Cigna allows an enrollee, the enrollee's designee or the person who has issued a valid prescription for the enrollee to request and gain access to a clinically appropriate drug not otherwise covered by the health plan. This process complies with the state's utilization review requirements and this law.
2. If Cigna approves a request under this law for a drug not otherwise covered by the health plan, Cigna will treat the drug as an essential health benefit, including counting any cost sharing toward the plan's annual limit on cost sharing (out of pocket) and including it when calculating the plan's actuarial value.
3. Cigna will determine whether it will cover the drug requested and notify the enrollee, the enrollee's designee, if applicable, and the person who has issued the valid prescription for the enrollee of its coverage decision within 72 hours or 2 business days, whichever is less, following receipt of the request. If the request is approved, Cigna, will provide coverage of the drug for the duration of the prescription, including refills.
4. Cigna has a process by which an expedited review may be requested in urgent circumstances. Urgent circumstances

exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. When an expedited review has been requested, Cigna will determine whether it will cover the drug requested and notify the enrollee, the enrollee's designee, if applicable, and the person who has provided a valid prescription for the enrollee of its coverage decision within 24 hours following receipt of the request. If the request is approved, Cigna, will provide coverage of the drug for the duration of the urgency.

Prescription Drug Benefits

Limitations

Emergency Order

During a statewide state of emergency declared by the Governor, a prescription drug is covered in accordance with a valid prescription issued by a provider in a quantity sufficient for an extended period of time, not to exceed a 180-day supply. This does not apply to coverage of prescribed contraceptive supplies according to state law or coverage of opioids prescribed in accordance with limits set by state law.

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

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 following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; 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.
- 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.

Payment of Benefits

Assignment and Payment of Benefits

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

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

party, including, but not limited to, a provider of healthcare services/items.

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

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

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

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

Recovery of Overpayment

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. In addition, 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.

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.

Termination of Insurance

Special Continuation of Medical Insurance

If your Active Service ends because of temporary layoff or a work-related injury or occupational disease that you claim is



payable under Worker's Compensation, the Medical Insurance for you and your Dependents will be continued, upon payment of the required premium by you to your Employer, provided that you:

- were employed by your Employer for a period of at least 6 months ending on the day your Active Service ends;
- are not eligible for Medicare;
- elect such continuation within 31 days after the date the insurance would otherwise cease.

The insurance will be continued until the earliest of:

- the date you fail to make the required contribution;
- the date you or your Dependent become eligible for similar group coverage or Medicare;
- the date the Compensation Board determines that the Injury or Sickness is not payable under Worker's Compensation;
- the end of one year from the last day of Active Service if your Active Service; or
- the date the policy is canceled.

In any case, the insurance on any one Dependent will cease on the date that the Dependent no longer qualifies as a Dependent as defined.

The provisions of this section will not operate to reduce any continuation of insurance otherwise provided.

Definitions

Evidence-Based Practices

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

Maximum Reimbursable Charge - Medical

The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule. You may be subject to balance billing from a non-Participating Provider as a result of a claims adjustment.

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies and who provides a service covered under the Plan. Other Health Professionals include, but are not limited to physical therapists, registered nurses, registered nurse first assistants, and licensed practical nurses, certified nurse practitioners, advanced practice nurses, physician assistants, certified midwives and nurse midwives, psychologists, certified nurse anesthetists, dentists, dental hygienists, naturopathic physicians, social workers, pastoral counselors, clinical professional counselors and marriage and family therapists.

Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

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

CERTIFICATE RIDER – Maryland Residents

Rider Eligibility: Each Employee who is located in Maryland

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

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

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

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

HC-ETMDRDR

Important Notices

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

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

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

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

Qualified Medical Child Support Order Defined

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

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

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

Claims

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

Payment of Benefits

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

Termination of Coverage Under a QMCSO

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

HC-IMP215

01-16
ET1

The Schedule

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

Note: OB/GYN provider is considered a Specialist.

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

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

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

The Medical Schedule is amended to indicate the following:

PSA, PAP Smear and Mandated Screening Tests

Screenings Include:

- Osteoporosis prevention and treatment including bone mass measurement

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

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

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

Outpatient Facility Services

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

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

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

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

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

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

Additional Benefits and Provisions

Calendar or Contract Year Maximum: Unlimited

Includes:

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

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

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

Inpatient

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

Residential Crisis Services

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

Physician’s Office Visit

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

Partial Hospitalization and Outpatient Facility

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

SCHEDMD-ET1

The Schedule

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

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

SCHED MD

ET-24

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.

SCHEDMD-ET7

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.

HC-COV1262

12-23
V1-ET2

Clinical Trials

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

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

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

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

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

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

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

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

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

Examples of routine patient care costs and services include:

- radiological services;
- laboratory services;

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

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

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

HC-COV1154

01-21
ET

Vision Benefits

For You and Your Dependents

Covered Expenses

Vision Benefits Extension Upon Coverage Termination

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

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

This provision will not apply, however, if:

- coverage is terminated because an individual fails to pay a required premium;
- coverage is terminated for fraud or material misrepresentation by the individual; or

- any coverage provided by a succeeding vision benefit plan is provided at a cost to the individual that is less than or equal to the cost of the extended benefit required under this provision, and does not result in an interruption of benefits.

HC-VIS45

05-23
V1-ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

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

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

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

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

treatment of medically-diagnosed congenital defects and birth abnormalities or premature birth.

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

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

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

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

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

improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

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

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

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

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

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

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

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

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

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

- charges made for hormone replacement therapy services for peri- and postmenopausal women and for outpatient contraceptive drugs or devices which have been approved by the Food and Drug Administration (FDA), under the same terms and conditions as for other outpatient prescription drugs and devices.

- charges made for cardiac rehabilitation, according to standards developed by the Massachusetts Department of Public Health. Cardiac rehabilitation means a multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease, provided in either a Hospital or other setting and meeting standards set forth by the Massachusetts Commissioner of Public Health.
- charges for Medically Necessary diabetes-related items and services:
 - Diabetes self-management training and education, including medical nutrition therapy when provided by a certified diabetes health care provider.
 - Laboratory tests, including glycosylated hemoglobin or HbA1c, urinary protein/microalbumin and lipid profiles.
 - Durable medical equipment:
 - Blood glucose monitors;
 - Voice synthesizers for blood glucose monitors for use by the legally blind;
 - Visual magnifying aids for the legally blind.
- Prosthetics:
 - Therapeutic/molded shoes and shoe inserts (when certified by the treating Physician and prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist or pedorthist).
- coverage for the cost of HLAT or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. Coverage includes the cost of testing for A, B, or DR antigens, or any combination thereof, consistent with rules, regulations, and criteria established by the Department of Public Health.
- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage of oral contraceptives.
- charges for medical or drug treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome including, but not limited to reconstructive surgery, such as suction assisted lipectomy, other restorative procedures and dermal injection or fillers for reversal of facial lipoatrophy syndrome.

Nutritional Counseling

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

Enteral Nutrition

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

Coverage includes:

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

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Mental Health and Substance Use Disorder Services

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

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

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

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

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

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

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

Inpatient Services

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

Intermediate Services

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

- Acute and other residential treatment.
- Clinically managed detoxification services.
- Partial hospitalization.

- Intensive Outpatient Programs (IOP).
- Day treatment.
- Crisis stabilization.

Outpatient Services

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

Mental Health and Substance Use Disorder Services for Children and Adolescents

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

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

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

Intermediate Services

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

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

Outpatient Services

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

- In-home therapy is Medically Necessary therapeutic clinical intervention or ongoing training, as well as therapeutic support; provided however, that the intervention or support shall be provided where the child resides, including in the

child's home, a foster home, a therapeutic foster home, or another community setting.

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

formal and informal services and supports in their communities, including parent support and self-help groups.

- Therapeutic mentoring services are Medically Necessary services provided to a child, designed to support age-appropriate social functioning or to improve deficits in the child's age-appropriate social functioning resulting from a DSM diagnosis; these services may include supporting, coaching, and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution, and relating appropriately to other children and adolescents and to adults. Such services must be provided, when indicated, where the child resides, including in the child's home, a foster home, a therapeutic foster home, or another community setting. Therapeutic mentoring is a skill building service addressing one or more goals on the youth's behavioral health treatment plan. It may also be delivered in the community, to allow the youth to practice desired skills in appropriate settings.

Exclusions

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

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

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External Prosthetic Appliances and Devices

Scalp Hair Prostheses

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

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Infertility Services

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

Infertility is defined as:

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

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

However, the following are excluded infertility services:

- donor charges and services.

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Medical Pharmaceuticals

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

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

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

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

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the



coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

HC-COV1396

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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.

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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.

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Definitions

Dependent

Dependents include:

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

A child includes:

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

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

HC-DFS1686

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Prescription Drug Product

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

HC-DFS1831

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

CERTIFICATE RIDER – Michigan Residents

Rider Eligibility: Each Employee who is located in Michigan

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

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

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

HC-ETMIRD

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.

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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.

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The Schedule

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

Out-of-Network Emergency Services Charges

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

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

The medical schedule is amended to add the following paragraph:

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

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

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

The provider may not attempt to collect from you any amount in excess of applicable cost-sharing amounts (any applicable

deductible, copay or coinsurance) based upon the allowable amount.

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 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).
- diabetes self-management training at initial diagnosis, and at significant changes in symptoms, conditions, or treatment.

HC-COV1493

01-24
ET

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

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-COV1508

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

- 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 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, 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.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges related to an Injury or Sickness payable under worker's compensation or similar laws.

HC-PHR736

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 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.

HC-EXC587

01-24
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 hereon 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-SPP82

01-24
ET

Important Information About Your Medical Plan

Standing Referral:

If your plan requires a referral from your PCP, then you may apply for and, if appropriate, receive a standing referral to a health care provider who is a specialist. A standing referral to a specialist qualified to treat the specific condition must be given for visits to such a specialist if benefits for such treatment are provided under the health plan and the enrollee has any of the following conditions:

- a chronic health condition;
- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;
- a degenerative disease or disability; or
- any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist.

HC-IMP301

01-21
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-PRA59

01-21
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

SCHEDMN-ET

Covered Expenses

- 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.
- additional coverage of post delivery care for mother and baby:
 - comprehensive postnatal visit with a health care provider not more than 3 weeks from the date of delivery;
 - any postnatal visits recommended by a health care provider between 3 and 11 weeks from the date of delivery; and
 - a comprehensive postnatal visit with a health care provider 12 weeks from the date of delivery.

A comprehensive postnatal visit means a visit with a health care provider 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-COV1252

01-24
ET

Covered Expenses

- charges made for routine procedures for cancer screening, including mammograms, digital breast tomosynthesis, Papanicolaou tests, colorectal screening tests for men and women, and ovarian cancer screening for women considered at risk due to a prior positive test for BRCA1 or BRCA2 mutations; or a family history of: one or more first or second degree relatives with ovarian cancers; clusters of women relatives with breast cancer; or nonpolyposis colorectal cancer.
- charges for general anesthesia and for associated Hospital or facility charges for dental care for your Dependent child who is under the age of five (5) or who is severely disabled, or who has a medical condition and requires hospitalization or general anesthesia for dental care treatment. Pre-authorization of hospitalization is required. Coverage may also include general anesthesia and treatment provided by a licensed Dentist for a covered medical condition, regardless if the services are provided in a Hospital or in a dental office.

HC-COV928

01-20
ET

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

Reconstructive Surgery

Coverage for congenital malformation for newborn infants immediately from the moment of birth; includes benefits for inpatient or outpatient expenses arising from medical and dental treatment up to the limiting age for coverage of the dependent, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

Benefits for individuals age 19 up to the limiting age for coverage of the Dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the Dependent turning age 19.

If orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan

shall be primary and the other policy or contract shall be secondary.

HC-COV1149

01-21
ET1

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

You will need to obtain prior approval from Cigna's 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.

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-PHR317

01-19
ET

Exclusions

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-PHR578

01-24
ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of 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.

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

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

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

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

HC-EXC499

01-24
ET

Termination of Insurance

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-TRM222

01-24
ET1

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 without requirement of premium 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; or
- the date you or your Dependent is no longer Hospital Confined;

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.

HC-BEX36

04-10
VI-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.

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service toll-free number that appears on your Benefit Identification card, explanation of benefits or claim form. You may also submit your complaint in writing. If you would like assistance completing a written complaint, please call us and we will assist you. You will receive an acknowledgement letter within 10 business days from when we receive your complaint. You



will have the opportunity to provide additional clarifying information as needed at that time.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the Appeals Procedure.

Appeals Procedure

Cigna has a one step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 180 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna
National Appeals Organization (NAO)
P.O. Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

We will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 14 calendar days and to specify any additional information needed to complete the review. We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 14 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services.

If you request that your appeal be expedited, you may also ask for an Expedited External Independent Review at the same time, if the time to complete an expedited level one appeal would be detrimental to your medical condition.

Cigna's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

External Review Procedure

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding an adverse determination including: an appeal or complaint decision related to a health care service or claim that is partially or wholly adverse to you; or an upheld determination not to certify on the basis that the service was not Medically Necessary that has been appealed and the appeal did not reverse the initial determination, you may request that your appeal be referred to an External Review Entity. The request for an External Review must be made within six (6) months of the date of the adverse determination.

Under most circumstances you must exhaust the internal complaint or appeal process prior to an External Review. However, you may proceed to an External Review without exhausting the internal complaint or appeal process under the following circumstances: Cigna waives the exhaustion requirement; Cigna is considered to have waived the exhaustion requirement by failing to substantially comply with any requirements including, but not limited to, time limits for internal complaints or appeals; or you have applied for an Expedited External Review at the same time you qualify for and apply for an Expedited Internal Review for adverse determinations involving medical necessity denials.

The External Review Entity is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is a \$25 filing fee for you to initiate this External Review process, which may be waived by the commissioner of health or commerce in cases of financial hardship and must be refunded if the adverse determination is completely reversed. No enrollee may be subject to filing fees totaling more than \$75 during a plan year for group coverage or policy year for individual coverage. Cigna will abide by the decision of the External Review Entity.

To request a review, you must submit the application form for an External Review accompanied by the \$25 filing fee to the Minnesota Department of Commerce after your receipt of Cigna's level two appeal review denial. Cigna will then forward the case file to the External Review Entity.

External Review Process for Review, Determination, and Communication

Upon receiving a request for an External Review, the commissioner will assign an External Review Entity on a random basis. The assigned External Review Entity will provide immediate notice of the review to you and to Cigna.

Within ten business days of receiving notice of the review, you and Cigna must provide the assigned External Review Entity with any information that they wish to be considered. Each party will be provided an opportunity to present its version of the facts and arguments. The assigned External Review Entity must furnish to Cigna any additional information submitted by you within one business day of receipt. You may be assisted or represented by a person of your choice.

As part of the External Review process, any aspect of an External Review involving a medical determination must be performed by a health care professional with expertise in the medical issue being reviewed.

An External Review will be held as soon as practical but in no case later than 45 days after receiving the request for an External Review and the External Review Entity must promptly send written notice of the decision and the reasons for it to you, Cigna, and the commissioner. The External Review Entity and the clinical reviewer assigned must not have a material professional, familial, or financial conflict of interest with Cigna, the member, provider, or facility.

Expedited External Review

An Expedited External Review must be provided if you request it after receiving:

- an adverse determination that involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have simultaneously requested an expedited internal appeal;
- an adverse determination that concerns an admission, availability of care, continued stay, or health care service for which you received emergency services but have not been discharged from a facility;
- or an adverse determination that involves a medical condition for which the standard External Review time would seriously jeopardize your life or health or jeopardize your ability to regain maximum function.

The External Review Entity must make its expedited determination to uphold or reverse the adverse determination as expeditiously as possible but within no more than 72 hours

after the receipt of the request for expedited review and notify you and Cigna of the determination.

If the External Review Entity's notification is not in writing, the External Review Entity must provide written confirmation of the determination within 48 hours of the notification.

A decision rendered is not binding on you, but will be binding on Cigna. Cigna may seek judicial review of the decision on the grounds that the decision was arbitrary and capricious or involved an abuse of discretion.

Assistance from the State of Minnesota

You have the right to contact the Minnesota Department of Commerce for assistance at any time. The commissioner may be contacted at the following address and telephone number:

Minnesota Department of Commerce
External Appeal Process
85 7th Place East, Suite 280
St. Paul, MN 55101
Toll-Free Number: 1-800-657-3602
Fax Number: 651-539-0105

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

If your plan is governed by ERISA, you also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which: was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action. However, no action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after a written proof of claim has been filed in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of claim is required to be furnished.

HC-APL429

01-24
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Definitions

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.

HC-DFS1018

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

CERTIFICATE RIDER – Nebraska Residents

Rider Eligibility: Each Employee who is located in Nebraska

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

HC-ETNERDR

Covered Expenses

- charges made for one screening test for hearing loss for a Dependent child from birth through 31 days old.

HC-COV1455

01-24
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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.

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or

a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service toll-free number that appears on your benefit identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 15 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

To initiate an appeal for most claims, you must submit a request for an appeal within 180 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your benefit identification card, explanation of benefits or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity (adverse determination) or clinical appropriateness will be considered by a health care professional. When reasonably necessary or when requested by the provider acting on your behalf, appeals involving adverse determination shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed.

Within three working days after we receive your appeal you will be notified of your right to submit written material, and to have the name, address, and telephone number of the person designated to coordinate your appeal.

You do not have the right to attend, or to have a representative attend, the appeal review.

We will respond in writing with a decision within 15 calendar days after we receive an appeal for a required pre-service or concurrent care coverage determination (decision). We will



respond within 15 calendar days after we receive an appeal for a post-service coverage determination.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

If we cannot make a decision within fifteen calendar days due to circumstances beyond our control, for any appeals except those dealing with adverse determinations, we will notify you in writing on or before the fifteenth day after receiving your appeal, as to the reason for the delay, and to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. Decisions for appeals involving adverse determinations will be made and you will be notified in writing on or before the fifteenth day after receiving your request.

If the appeal of your adverse determination did not resolve the difference of opinion between you and Cigna, you or the provider acting on your behalf may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services.

If you request that your appeal be expedited you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited appeal would be detrimental to your medical condition.

Cigna's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the names, titles, and qualifying credentials of the person or persons acting as the reviewer in the grievance process and also a statement of the reviewer's understanding of the person's grievance; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement

that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency. You may also contact the Plan Administrator.

Independent External Review Procedure

If you are not fully satisfied with the decision of Cigna's appeal review regarding your Medical Necessity, clinical appropriateness, health care setting, experimental or investigational nature, level of care or effectiveness of the health care service or treatment issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review process. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity, clinical appropriateness, experimental or investigational, health care setting, level of care or effectiveness of the health care service or treatment determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Nebraska Department of Insurance within 4 months of your receipt of Cigna's appeal review denial.



The form required to request an external appeal will be provided with a final adverse benefit determination. In addition, the forms may be accessed on the Cigna website or on the Department of Insurance Website at www.doi.nebraska.gov.

Within one business day after the date of receipt of a request for an external review, the director from the Nebraska Department of Insurance will send a copy of the request to Cigna. Within five business days following the date of receipt of the copy of the external review request from the director, Cigna will complete a preliminary review of the request. Within one business day after the completion of the preliminary review, Cigna will notify the director and you, or your authorized representative, in writing whether:

- the request is complete; and
- the request is eligible for external review.

The director from the Nebraska Department of Insurance may determine that a request is eligible for external review notwithstanding Cigna's initial determination that the request is ineligible.

The director shall, within one business day after the date of receipt of the notice assign an Independent Review Organization.

The Independent Review Organization will provide a decision for standard external reviews within 45 days of receiving the request for review.

When a delay would be detrimental to your condition, a request for an expedited external review can be submitted to the director of the Nebraska Department of Insurance. An expedited external review is available only if your treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize your life or would jeopardize your ability to regain maximum function. The director will immediately send the request to Cigna. Cigna will determine if the request meets the reviewability requirements. Cigna shall immediately notify the director and you and, if applicable, your authorized representative of its eligibility determination. The notice of initial determination shall include a statement informing you and, if applicable, your authorized representative that Cigna's initial determination that an expedited external review request is ineligible for review may be appealed to the director. If the request is eligible for an expedited external review, the Independent Review Organization will render its decision within 72 hours of receipt of the request.

Assistance from the State of Nebraska

You have the right to contact the Nebraska Department of Insurance for assistance at any time. The Director may be contacted at the following address and telephone number:

Nebraska Department of Insurance
PO Box 95087
Lincoln, NE 68509-5087
Telephone: 877-564-7323
www.doi.nebraska.gov

Adverse Determination

Adverse determination means a determination by a health carrier or its designee utilization review organization that an admission, the availability of care, a continued stay, or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for Medical Necessity, clinical appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the internal appeal process. However, no action will be brought at all unless brought within three years after a claim is submitted for In-Network services or for Out-of-Network services.

HC-APL444

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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.

In the event a prescription drug is not approved for use by Cigna through the Step Therapy process for the specific medical condition requested, you or the prescribing Physician may request an override exception. A determination for an override request will be rendered within 5 calendar days after receipt of complete, clinically relevant written documentation supporting a step-therapy override exception for a standard request, and 72 hours after receipt of such documentation for an urgent request. If an override exception request is incomplete or additional clinically relevant information is required, the Plan may request such information within the applicable time period provided in this section. Once the information is submitted, the applicable time period for approval or denial shall begin again. If the Plan fails to respond to the request for a step-therapy override exception within the applicable time, the step-therapy override exception shall be deemed granted.

HC-PHR615

01-22
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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not 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.

HC-EXC572

01-24
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Nevada Residents

Rider Eligibility: Each Employee who is located in Nevada

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

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

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

HC-ETNVRDR

Important Notices

Nevada Division of Insurance

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

**The Department of Business Industry,
Division of Insurance**

Toll free number: (888) 872-3234

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

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

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

HC-IMP48

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Covered Expenses

- charges for Medically Necessary biomarker testing for the diagnosis, treatment, appropriate management, and ongoing monitoring of cancer when biomarker testing is supported by medical and scientific evidence.
- charges for testing, treatment, and prevention of sexually transmitted disease.
- charges for Medically Necessary treatment of conditions related to gender dysphoria and gender incongruence.
- charges for a drug that has been prescribed for the treatment of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration if that drug has been recognized as a treatment for cancer by either the American Hospital Formulary Services Drug Information; US Pharmacopoeia Drug Information; or supported by at least two articles published in accepted scientific medical journals. Coverage will also be provided for any medical services necessary to administer the drug.

HC-COV1408

01-24
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Limitations

Step Therapy

Certain Prescription Drug Products are subject to step therapy 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 determined within 48 hours. See your appeals section for your appeal rights.

These requirements do not apply to prescription drugs associated with the treatment of stage three or four cancer or associated conditions.

Step Therapy for Psychiatric Conditions

Cigna will not require you to participate in a step therapy program before covering a drug if:

- The drug has been approved by the FDA to treat a psychiatric condition supported by medical or scientific evidence;

- The drug is prescribed by:
 - a psychiatrist;
 - a physician assistant under the supervision of a psychiatrist;
 - an advanced practice registered nurse who has psychiatric training and experience prescribed by the State Board of Nursing;
 - a primary care provider that is providing care to an insured in consultation with a network psychiatrist or physician assistant;
- The health care provider who prescribed the drug knows, based on the medical history of the insured, or reasonably expects each alternative drug that is required to be used earlier in the step therapy program to be ineffective at treating psychiatric condition.

HC-PHR681

01-24
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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

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

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

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

HC-EXC552

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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.

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service toll-free number that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the Appeals Procedure.

Appeals Procedure

Cigna has a two step Appeals Procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. You can call us at the Customer Service toll-free number that appears on your Benefit Identification card, explanation of benefits or claim form, or you can write to us at the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services.

If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level one appeal would be detrimental to your medical condition.

Cigna's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.



Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

A second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician Reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician Reviewer. You may present your situation to the Committee in person or by conference call.

For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services, or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician Reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Step Therapy Exemption Appeals

Cigna will respond with an approval or denial decision within 48 hours from when the appeal is submitted. For situations that the provider notes as urgent, Cigna will respond to the

request for appeal within 24 hours after the appeal is submitted.

Independent External Review Procedure

If you are not fully satisfied with the decision of Cigna's level two appeal, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.

You may, within four months after receiving notice of the adverse determination, submit a request to the Office for Consumer Health Assistance for an external review of the adverse determination. Within five days after receiving a request, the Office for Consumer Health Assistance shall notify you and Cigna that the request has been filed and shall assign an Independent Review Organization.

Within five days after receiving notification specifying the Independent Review Organization assigned, Cigna will provide all documents and materials relating to the adverse determination.

The Independent Review Organization shall, within five days after receiving the request notify you and Cigna if any additional information is required to conduct a review of the adverse determination. Such additional information must be provided within five days. The Independent Review Organization will approve, modify or reverse the adverse determination within 15 days after it receives the information required to make that determination.

Expedited Independent External Reviews

The Office for Consumer Health Assistance will approve or deny a request for an external review of an adverse determination in an expedited manner not later than 72 hours after it receives proof from the provider of health care of the covered person that:

- the adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from the facility providing the services or care; or
- failure to proceed in an expedited manner may jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function.

If the Office for Consumer Health Assistance approves a request for an external review then it will assign the request to

an Independent Review Organization not later than one business day after approving the request. Within 24 hours after receiving notice assigning the request, Cigna will provide to the Independent Review Organization all required documents and materials.

An Independent Review Organization that is assigned to conduct an external review will: complete its external review not later than 48 hours after receiving the assignment, unless the covered person and Cigna agree to a longer period; not later than 24 hours after completing its external review, notify the covered person, the Physician of the covered person, the authorized representative, if any, and Cigna by telephone of its determination; and not later than 48 hours after completing its external review, submit a written decision of its external review to the covered person, the Physician of the covered person, the authorized representative, if any, and Cigna.

External Review - Experimental or Investigational

Within four months after receipt of a notice of an adverse determination that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, you may file a request for external review with the Office for Consumer Health Assistance. You may make an oral request for an expedited external review if the covered person's treating Physician certifies, in writing, that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

Within one business day after receipt of a request for external review the Office for Consumer Health Assistance shall notify Cigna. Within five business days after receipt of the notice, Cigna will complete a preliminary review to determine if the request meets the requirements for review.

Within one business day after completion of the preliminary review, Cigna will notify the Office for Consumer Health Assistance and you whether the request is: complete; eligible for external review; not complete, in which case the health carrier shall include in the notice the information or materials that are needed to make the request complete; or not eligible for external review, in which case the health carrier shall include in the notice the reasons for its ineligibility.

The notice of initial determination must include a statement that a request which is ineligible for external review may be appealed to the Office for Consumer Health Assistance, and the Office for Consumer Health Assistance may determine that a request for an expedited external review is eligible for external review.

If Cigna determines that a request is eligible for external review, it will notify the Office for Consumer Health Assistance and you within one business day after receipt of the

notice from Cigna that the external review request is eligible for external review, the Office for Consumer Health Assistance will: assign an Independent Review Organization to conduct the external review; notify Cigna of the name of the assigned Independent Review Organization; and notify you in writing that the request is eligible for external review and provide the name of the assigned Independent Review Organization.

The notice will include a statement that you may submit in writing to the assigned Independent Review Organization within five business days additional information that the Independent Review Organization will consider when conducting the external review. The Independent Review Organization may accept and consider additional information submitted after the five business days have elapsed.

Within five business days after receipt of the notice, Cigna will provide to the assigned Independent Review Organization any documents and information considered in making the adverse determination. If Cigna fails to provide the documents and information within five business days, the assigned Independent Review Organization may terminate the external review and make a decision to reverse the adverse determination. If the Independent Review Organization elects to terminate the external review and reverse the adverse determination, the Independent Review Organization will immediately notify you, if applicable, Cigna and the Office for Consumer Health Assistance.

Within 20 days after receipt of the opinion of each clinical reviewer assigned to review the case, the assigned Independent Review Organization will make a decision and provide written notice of the decision to you, Cigna, and the Office for Consumer Health Assistance.

Expedited External Reviews - Experimental or Investigational

Upon receipt of a request for an expedited external review, the Office for Consumer Health Assistance shall immediately notify Cigna, and Cigna will immediately determine whether the request meets the requirements for review. Cigna will immediately notify the Office for Consumer Health Assistance and you of its determination regarding eligibility. The notice of initial determination must include a statement that a request which is ineligible for external review may be appealed to the Office for Consumer Health Assistance, and the Office for Consumer Health Assistance may determine that a request for an expedited external review is eligible for external review. If the expedited external review meets the requirements for review, the Office for Consumer Health Assistance will immediately assign an Independent Review Organization and notify Cigna of the name of the assigned Independent Review Organization. Cigna will provide or transmit any documents



and information considered in making the adverse determination to the assigned Independent Review Organization electronically or by telephone or facsimile, or any other available expeditious method. Within 48 hours after receipt of the opinion of each clinical reviewer the assigned Independent Review Organization will make a decision and provide notice of the decision orally or in writing to you, Cigna and the Office for Consumer Health Assistance. If the notice provided was not in writing, within 48 hours after providing that notice, the assigned Independent Review Organization will provide written confirmation of the decision to you, Cigna, and the Office for Consumer Health Assistance.

Final Decision

If the determination of an Independent Review Organization concerning an external review of an adverse determination is in favor of the covered person, the determination is final, conclusive and binding upon Cigna. Cigna will immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination. The cost of conducting an external review of an adverse determination will be paid by Cigna.

Assistance from the State of Nevada

You have the right to contact the Consumer Service Section for assistance at any time. The Consumer Service Section may be contacted at the following address and telephone number:

For Carson City:
1818 E. College Parkway
Carson City, NV 89706
1-888-872-3234

For Las Vegas:
3300 W. Sahara Ave, Suite 275
Las Vegas, NV 89102
1-888-872-3234

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a

determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action. However, no action will be brought at all unless brought within three years after a claim is submitted for In-Network services or within three years after proof of claim is required under the plan for Out-of-Network services.

HC-APL459

01-24
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Definitions

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

Domestic Partner

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

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

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

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

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

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

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-ETNJRD

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-DFS709

01-15
ET

HC-IMP17

04-10
V1-ET

Covered Expenses

- Covered Expenses will include expenses incurred for charges made for Preventive Care consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:
 - charges made for the following health wellness tests and services for all persons:
 - 20 years of age and older, annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, instead, low-density

lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level.

- 35 years of age or older, a glaucoma eye test every five years.
- 40 years of age or older, an annual stool examination for presence of blood.
- 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years.
- 20 years of age and older, an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-exam and seat belt usage in motor vehicles.
- charges made for the following health wellness tests and services for all women:
 - 20 years of age and older; a Pap smear as recommended by a Physician.
 - 40 years and older, a mammogram annually; for all adults, recommended immunizations.
- such coverage is excluding any charges for:
 - 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.

Other wellness tests and time schedules will be covered upon the recommendation of a Physician. Any In-Network Deductible will be waived for these preventive care services.

- charges made for expenses incurred in screening adolescents between the ages of 12 and 18 for major depressive disorder, so long as screening for major depressive disorder in adolescents continues to receive a rating of “A” or “B” from the United States Preventative Services Task Force. Coverage may not be denied solely on the basis that the screening is provided in conjunction with any other health care evaluation, treatment, or service. Such benefits are exempt from any form of cost sharing, including, but not limited to, Copayments, Deductibles, or Coinsurance. Additionally, Covered Expenses include charges for childhood immunizations as recommended by the Advisory Committee on Immunization practices of the U.S. Public Health Service, the Department of Health and the New Jersey Department of Health and Senior Services for a Dependent child during that child’s lifetime.

HC-COV1295

01-24
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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
ET

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
VI-ET

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

CERTIFICATE RIDER – New York Residents

Rider Eligibility: Each Employee who is located in New York

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

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

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

HC-ETNYRDR

SECTION X. Additional Benefits, Equipment and Devices

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

Enteral Nutrition

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

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

SECTION XI. Inpatient Services

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

A. End of Life Care.

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

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

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

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

HC-COV1251

1/1/23
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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-PHR577

1/1/23
ET1

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

CERTIFICATE RIDER – North Carolina Residents

Rider Eligibility: Each Employee who is located in North Carolina

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

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

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

HC-ETNCRDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days,

coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

HC-ELG243

01-19
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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.
- charges made for surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) excluding orthodontic treatment.

HC-COV1433

01-24
ET1

Prescription Drug Benefits

Exclusions

- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.

HC-PHR674

01-24
ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem. This does not include coverage for congenital defects or anomalies.

HC-EXC560

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

Dependent – Applies to Vision Only

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

HC-DFS256

04-10
V1-ET



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

CERTIFICATE RIDER – Ohio Residents

Rider Eligibility: Each Employee who is located in Ohio

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

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

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

HC-ETOHDRD

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.
- charges for diagnostic and exploratory procedures to determine infertility, including surgical procedures to correct the medically diagnosed disease or condition of reproductive organs, including but not limited to endometriosis, collapsed/clogged fallopian tubes or testicular failure; in vitro fertilization, gamete intrafallopian transfer and zygote intrafallopian transfer are not covered.

Maternity

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

Inpatient care will include:

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

Post-discharge Follow-up

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

Follow-up services will include:

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

Virtual Care - Medical

Dedicated Virtual Providers/Telemedicine

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

Virtual Physician Services/Telemedicine

Includes charges for the delivery of 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.

- 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-COV1399

01-24
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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

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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.

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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.

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Payment of Benefits

Recovery of Overpayment on a Provider Claim

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

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

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

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

HC-POB149

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Medical Conversion Privilege

For You and Your Dependents

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

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

Employees Entitled to Convert

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

- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.

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

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

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

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

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered Under the Medical Plan

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

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or

devices that are determined by the utilization review Physician to be:

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

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

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

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.

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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

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When You Have A Complaint Or An Appeal

Definitions

“Adverse benefit determination” means a decision by a health plan issuer:

- To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
 - A determination that the health care service does not meet the health plan issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
 - A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage;
 - A determination that a health care service is not a covered benefit;
 - The imposition of an exclusion, including exclusions for source of Injury, network, or any other limitation on benefits that would otherwise be covered.
 - Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
 - To rescind coverage on a health benefit plan.

“Authorized representative” means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

- A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;
- A person authorized by law to provide substituted consent for a covered individual;
- A family member or a treating health care professional, but only when the covered person is unable to provide consent.

“Covered person” means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan.

“Covered person” does include the covered person's authorized representative with regard to an internal appeal or external review.

“Covered benefits” or **“benefits”** means those health care services to which a covered person is entitled under the terms of a health benefit plan.

“Final adverse benefit determination” means an adverse benefit determination that is upheld at the completion of a health plan issuer’s internal appeals process.

“Health benefit plan” means a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

“Health care services” means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

“Health plan issuer” means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a Sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. “Health plan issuer” includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.

“Independent review organization” means an entity that is accredited to conduct independent external reviews of adverse benefit determinations.

“Rescission” or “to rescind” means a cancellation or discontinuance of coverage that has a retroactive effect.

“Rescission” does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

“Stabilize” means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person’s medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the covered person 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.

In the case of a woman having contractions, “stabilize” means such medical treatment as may be necessary to deliver, including the placenta.

“Step Therapy Exemption” means an overriding of a step therapy protocol in favor of immediate coverage of the health care provider’s selected prescription drug.

“Superintendent” means the superintendent of insurance.

When You Have a Complaint

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 you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Customer Service

We are here to listen and to help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Internal Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing, within 365 days of receipt of a denial notice, to the following address:

Cigna HealthCare, Inc.
National Appeals Organization (NAO)
P.O. Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at 800.Cigna.24/800.244.6224 or the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

We will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision).

We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours.

Step Therapy Exemption Appeals

We will respond with an approval or denial within 48 hours for a request related to urgent care services and 10 calendar days for all other requests.

Understanding the External Review Process

Under Chapter 3922 of the Ohio Revised Code all health plan issuers must provide a process that allows a person covered under a health benefit plan or a person applying for health benefit plan coverage to request an independent external review of an adverse benefit determination. This is a summary of that external review process. An adverse benefit determination is a decision by Cigna to deny benefits because services are not covered, are excluded, or limited under the plan, or the covered person is not eligible to receive the benefit.

The adverse benefit determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An adverse benefit determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of

Insurance. The covered person does not pay for the external review. There is no minimum cost of health care services denied in order to qualify for an external review. However, the covered person must generally exhaust the health plan issuer's internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the adverse benefit determination.

External Review by an IRO - A covered person is entitled to an external review by an IRO in the following instances:

- The adverse benefit determination involves a medical judgment or is based on any medical information.
- The adverse benefit determination indicates the requested service is experimental or investigational, the requested health care service is not explicitly excluded in the covered person's health benefit plan, and the treating Physician certifies at least one of the following:
 - Standard health care services have not been effective in improving the condition of the covered person.
 - Standard health care services are not medically appropriate for the covered person.
 - No available standard health care service covered by Cigna is more beneficial than the requested health care service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 7 days and can be requested if any of the following applies:

- The covered person's treating Physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal.
- The covered person's treating Physician certifies that the final adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
- The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not yet been discharged from a facility.
- An expedited internal appeal is already in progress for an adverse benefit determination of experimental or

investigational treatment and the covered person's treating Physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective final adverse benefit determinations (meaning the health care service has already been provided to the covered person).

External Review by the Ohio Department of Insurance - A covered person is entitled to an external review by the Department in the either of the following instances:

- The adverse benefit determination is based on a contractual issue that does not involve a medical judgment or medical information.
- The adverse benefit determination for an emergency medical condition indicates that medical condition did not meet the definition of emergency AND Cigna's decision has already been upheld through an external review by an IRO.

Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the covered person, or an authorized representative, must request an external review through Cigna within 180 days of the date of the notice of final adverse benefit determination issued by Cigna.

All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally. The covered person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete Cigna will initiate the external review and notify the covered person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the covered person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. Cigna will also forward all documents and information used to make the adverse benefit determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete Cigna will inform the covered person in writing and specify what information is needed to make the request complete. If Cigna determines that the adverse benefit determination is not eligible for external

review, Cigna must notify the covered person in writing and provide the covered person with the reason for the denial and inform the covered person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by Cigna and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the health benefit plan and all applicable provisions of the law.

IRO Assignment

When Cigna initiates an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with Cigna, the covered person, the health care provider or the health care facility will not be selected to conduct the review.

IRO Review and Decision

The IRO must consider all documents and information considered by Cigna in making the adverse benefit determination, any information submitted by the covered person and other information such as; the covered person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the health benefit plan, the most appropriate practice guidelines, clinical review criteria used by the health plan issuer or its utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by Cigna of a request for a standard review or within 72 hours of receipt by Cigna of a request for an expedited review. This notice will be sent to the covered person, Cigna and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review.
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- The dates over which the external review was conducted.
- The date on which the independent review organization's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.



NOTE: Written decisions of an IRO concerning an adverse benefit determination that involves a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

Binding Nature of External Review Decision

An external review decision is binding on Cigna except to the extent Cigna has other remedies available under state law. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law.

A covered person may not file a subsequent request for an external review involving the same adverse benefit determination that was previously reviewed unless new medical or scientific evidence is submitted to Cigna.

If You Have Questions About Your Rights or Need Assistance

You may contact Cigna:

Cigna HealthCare Inc.
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422
1-800-Cigna24
www.Cigna.com

You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300
Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

Contact ODI Consumer Affairs:

<https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp>

File a Consumer Complaint:

<http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx>

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse benefit determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse benefit determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge,

reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); and upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse benefit determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse benefit determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One Appeal process.

HC-APL357

01-24

VI-ET



Definitions

Dependent

Dependents are:

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

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

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

HC-DFS1690

01-23
ET

Synchronous, Real Time Communication

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

HC-DFS1335

03-19
ET

Teledentistry

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

HC-DFS1336

03-19
ET

Telemedicine/Virtual Care

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

HC-DFS1526

ET

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

CERTIFICATE RIDER – Oregon Residents

Rider Eligibility: Each Employee who is located in Oregon

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

HC-ORM-04-11

HC-ETORRDR

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Our Commitment to Quality

At Cigna, one of our goals is to work in cooperation with participating physicians to provide you with access to quality care and programs. Cigna's Quality Management Program is based on industry standards and objective measures that help us evaluate the quality of care and services received by Cigna plan members.

The program also helps us better focus our improvement efforts. The Quality Management Program allows for input from our members and providers through regular analysis of the following items and reports the findings to various quality committees in order to effectively target areas in need of improvement and efficiently monitor change:

- Credentialing process for qualified physicians;
- Ongoing assessment of clinical activities and services provided to Cigna plan members;
- Utilization Management activities and programs for Cigna plan members;
- Programs dedicated to communicating and administering members Rights and Responsibilities.

You have the right to participate in developing plan policy. You may do so by calling us at the telephone number on your Cigna ID card with your opinions, ideas and thoughts.

Additionally, your participation in plan surveys gives direct feedback on plan performance and policy developments. On an annual basis, we evaluate our program to determine our success and identify opportunities for further improvement to focus on for the following year.

Should you wish to receive information about Cigna's Quality Management Program and/or copies of the annual summaries Cigna files with the state of Oregon, please call the toll-free number on your Cigna ID card. The following summaries are available to you free of charge:

- annual summary of grievances and appeals;
- annual summary of utilization review policies;
- annual summary of quality assessment activities;
- the results of all publicly available accreditation surveys;
- annual summary of health promotion and disease prevention activities;
- annual summary of scope of network and accessibility of services.

This information is also available from the Oregon Division of Financial Regulation:

- by calling (503) 947-7984 or the toll free message line at (888) 877-4894;
- by writing to the Oregon Division of Financial Regulation Consumer Protection Unit,
P.O. Box 14480 Salem
OR 97309-0405;
- through the Internet at <http://www.dfr.oregon.gov> or
- by e-mail at: DFR.InsuranceHelp@oregon.gov

Choosing a Primary Care Physician

We encourage you and your covered family members to choose a primary care physician to serve as your personal physician. Your relationship with your personal physician is a key to maintaining good health. Your personal physician can be a valuable resource and a personal health advocate. A primary care physician will be assigned for you if you have not selected one for you **or your Dependent(s)** by the 90th day of the plan year.

Start with the Cigna Directory, or visit our interactive Web site, www.cigna.com.

- Listings include the doctor's address, phone number and specialties.
- We are expanding our provider network and we may have added doctors in your area since we last updated our directories. If a doctor you would like to see isn't listed, call Customer Service. We'll be able to tell you if he or she has recently joined our network.
- When you call to make an appointment, be sure to confirm that the doctor participates in the Cigna network and that he or she is accepting new patients.

Opportunity to Select a Primary Care Physician

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents. If you need assistance selecting your Primary Care Physician, please visit our website at www.cigna.com or call the number on the back of your ID Card.

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

You and your Dependents are allowed direct access to Participating Physicians for covered services. Even if you select a Primary Care Physician, there is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Physician of your choice, including Participating Specialist Physicians, for covered services.



Changing Primary Care Physicians

You may request a transfer from one Primary Care Physician to another by visiting our website at www.cigna.com or calling the number on the back of your ID Card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

Direct Access For Mental Health and Substance Use Disorder Services

You are allowed direct access to a licensed/certified Participating Provider for covered Mental Health and Substance Use Disorder Services. There is no requirement to obtain an authorization of care from your Primary Care Physician for individual or group therapy visits to the Participating Provider of your choice for Mental Health and Substance Use Disorder.

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the “Newborns’ and Mothers’ Health Protection Act”: restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Our Complaint-Handling Process

Cigna has established a process for addressing your concerns and solving your problems. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, please call us at the customer service toll-free number that appears on your Benefit Identification card, explanation of benefits or claim form.

If you are not satisfied with the results of a coverage decision, you have the right to file a grievance. For information about Cigna's grievance and appeal procedures, please see the section of this certificate entitled “When You Have a Complaint or Appeal”.

HC-IMP340

01-24

ET

The Schedule

The “External Prosthetic Appliances” provision in **The Schedule** of your medical certificate is amended to indicate the following:

No separate External Prosthetic Appliances maximum or benefit deductible shall apply.

SCHED OR

ET-6

Covered Expenses

- charges for newborn home visiting services, in-person and virtual.
- nurse home visiting services performed by a registered Nurse or Certified Traditional Health Worker to families caring for newborns up to the age of 6 months.
- services offered on a comprehensive newborn nurse home visit must include:
 - maternal physical assessment (if applicable) according to clinical guidelines approved by the Authority; newborn physical assessment according to clinical guidelines approved by the Authority; systematic assessment of family strengths, risks, and needs according to clinical guidelines approved by the Authority; screening for intimate partner violence, perinatal mood disorders and substance use using a validated screening tool; standardized anticipatory and supportive guidance according to clinical guidelines approved by the Authority; referrals for identified interventions or community resources as a result of needs identified by the home visitor during the home visit.
- charges for screening and counseling for domestic violence.



- charges made by a Physician for professional services including office visits for Employees and Dependents for pregnancy care which includes the care necessary to support a healthy pregnancy and care related to labor and delivery.

HC-COV1364

01-24
ET1

Mental Health and Substance Use Disorder Services

Charges for Medically Necessary medical services, including rehabilitation services, for a dependent child who has been diagnosed with a pervasive developmental disorder are covered. "Pervasive developmental disorder" means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability or intellectual disability. "Rehabilitation services" means physical therapy, occupational therapy or speech therapy services to restore or improve function.

HC-COV1366

01-24
ET

Craniofacial Abnormalities

- charges made for dental and orthodontic services for the treatment of Craniofacial Anomalies if the services are Medically Necessary to restore function.

Coverage does not include the treatment of:

- developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; or
- temporomandibular joint disorder.

Craniofacial Anomaly means a physical disorder identifiable at birth that affects the bony structures of the face or head, including but not limited to cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome.

HC-COV248

10-16
ET

Definitions

Certified Traditional Health Worker

Certified Traditional Health Workers are any of the following: a community health worker; a personal health navigator; a peer wellness specialist; a peer support specialist; a doula.

HC-DFS1683

01-23
ET

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. Coverage for such child will include the necessary care and treatment of medical conditions existing prior to the date of placement including medically diagnosed congenital defects or birth abnormalities. It also includes a grandchild who is considered your Dependent for federal income tax purposes or a stepchild.

HC-DFS1682

01-23
ET1

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

SCHEDDENE-ET1

The Schedule

The Medical Schedule is amended to indicate that **Enteral Nutrition (Nutritional Formulas)** is covered, subject to plan coinsurance without application of any plan deductible, except if you’re covered under a Qualified High Deductible Health Savings plan then the plan deductible will apply.

SCHEDPA-ET

Covered Expenses

- charges made for or in connection with breast cancer screening mammograms annually for women age 40 and over, and based on a Physician’s recommendation for women under age 40, including breast imaging: 3-D mammograms; supplemental magnetic resonance imaging (MRI); and for women at high risk for breast cancer as determined by the treating Physician, ultrasound.
- 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 non-symptomatic persons who are 50 years of age or older includes, but not be 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.

Coverage for symptomatic persons includes a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating Physician. “Symptomatic person” means an individual who experiences a change in bowel habits, rectal bleeding or persistent stomach cramps, weight loss or abdominal pain.

Coverage for a non-symptomatic person at high or increased risk for colorectal cancer who is under 50 years of age includes a colonoscopy or any combination of colorectal cancer screening tests in accordance with the American Cancer Society guidelines on screening for colorectal cancer published as of January 1, 2008. “Non-symptomatic person at high or increased risk” means an individual who poses a higher than average risk for colorectal cancer.

- for children under age 2, at least one blood lead test according to recommendations from the Centers for Disease Control and Prevention; and follow-up tests if initial test indicates an elevated blood lead level.
- 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.
- the following benefits will apply to insulin-dependent, and non-insulin-dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:
 - charges for Durable Medical Equipment, including glucometers; blood glucose monitors; insulin pumps; infusion devices and related accessories, including those adaptable for the legally blind; podiatric appliances; and glucagon emergency kits. A special maximum will not apply.
 - charges for training by a Physician with expertise in diabetes management, but limited to the following:
 - Medically Necessary visits when diabetes is diagnosed;
 - Medically Necessary visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
 - visits when reeducation or refresher training is prescribed by the Physician; and
 - medical nutrition therapy related to diabetes management.

Enteral Nutrition

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

Coverage includes Medically Necessary nutritional supplements for the treatment of inborn errors of metabolism (e.g. disorders of amino acid or organic acid metabolism).

Benefits for nutritional support (formulas) as Medically Necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a Physician shall be exempt from Deductible.

HC-COV1378

01-23
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-PHR648

01-23
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 may also include products in the following categories if specifically identified on the Prescription Drug List:

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

HC-DFS1676

01-22
ET



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

CERTIFICATE RIDER – 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 per person however, the 3 visit limit will not apply to treatment of diabetes.”

SCHEDDENE-ET1

Covered Expenses

- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage on oral contraceptives.
- charges made for Medically Necessary care and treatment of cleft lip and palate and any condition or illness which is related to or developed as a result of cleft lip and palate. This includes, but is not limited to oral/facial surgery, teeth capping prosthodontics, orthodontics, otolaryngology, and audiological care. If the procedures are also covered by a dental policy, medical benefits can be excluded for prosthodontics, including teeth capping, and orthodontics.
- charges for inpatient care for up to 48 hours after a vaginal delivery and up to 96 hours after a caesarean section for a mother and her newborn, payable as any other inpatient stay. The day of delivery or surgery will not count toward the length of stay. Any length of stay beyond the 48 or 96 hours will be covered if determined Medically Necessary. This does not prevent a mother and her newborn from being discharged earlier than the 48 or 96 hours if the mother and doctor agree to the earlier discharge.
- charges made for at least 48 hours of inpatient care following a mastectomy. A shorter stay is acceptable when ordered by the attending Physician. In the case of an early release, charges for at least one home care visit will be covered, if ordered by the Physician.
- charges for one mammogram for women age 35 to 39; one mammogram every two years for women age 40 to 49; and an annual mammogram for women age 50 and older.
- charges for an annual Pap smear, and additional Pap smears when recommended by a Physician.
- charges made for treatment of Autistic Disorder, Asperger's Syndrome, Pervasive Developmental Disorder - Not Otherwise Specified and ABA therapy. Coverage is limited

to treatment that is prescribed by the insured's treating medical doctor in accordance with a treatment plan, to include a diagnosis, proposed treatment by type, frequency, and duration of treatment, the anticipated outcomes stated as goals, the frequency by which the treatment plan will be updated, and the treating medical doctor's signature.

HC-COV1456

09-23
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 oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

HC-COV1241

01-22
ET

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by Cigna only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to Cigna within 60 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

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

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

If you retire you may apply for a Converted Policy within 60 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

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

- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death; (In the case of divorce, the former spouse must make written application and pay the required premium within 60 days after the entry of final decree.)
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

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

Overinsured

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

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

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

Converted Policy

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

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

effective date will be based on: class of risk and age; and benefits.

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

HC-CNV1

04-10

V3-ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

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

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

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the

utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of the prescribed indication in one of the following: United States Pharmacopoeia Drug Information; American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; or two articles from major peer-reviewed medical literature.

HC-EXC573

09-23
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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.

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The Following Will Apply To Residents Of South Carolina

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.

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Service toll-free number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by



applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 5 working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

External Review Procedure

You filed an appeal pursuant to Cigna's level one or level two processes and Cigna has not issued a written decision within the time frames for making a decision if Cigna has received all the information needed to complete the appeal review and you have not agreed to a delay.

Cigna has agreed to waive the completion of the level one or level two appeal processes.

To request a review, you must notify the Appeals Coordinator within 60 days of your receipt of Cigna's level two appeal denial. To request an expedited external review, you must notify the Appeals Coordinator within 15 days of your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Review Organization. Cigna will review all newly submitted information to determine if the appeal can be approved before being sent to the Independent Review Organization.

The Independent Review Organization will render an opinion on standard external review within 45 days. An expedited external review shall be completed as expeditiously as possible, but no later than within three days.

The Independent Review Program is a voluntary program arranged by Cigna.



Assistance from the State of South Carolina

You have the right to contact the South Carolina Department of Insurance for assistance at any time. The South Carolina Department of Insurance may be contacted at the following address and telephone number:

South Carolina Department of Insurance
1201 Main Street, Suite 1000
Columbia, SC 29201
803-737-6160

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action.

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Definitions

Dependent

The term child means a child born to you or a child legally adopted by you, including that child from the first day of placement in your home regardless of whether the adoption has become final, or an adopted child of whom you have custody according to the decree of the court provided you have paid premiums. Adoption proceedings must be instituted by you, and completed within 31 days after the child's birth date, and a decree of adoption must be entered within one year from the start of proceedings, unless extended by court order due to the child's special needs.

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Emergency Service/Emergency Medical Condition

Emergency Services are covered inpatient and outpatient services that are furnished by a qualified provider and are needed to evaluate or stabilize an Emergency Medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would result in one of the following:

- Placing the health of the individual, or with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

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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.

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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.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services toll-free number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. Cigna will acknowledge your request within 5 business days after said request. To initiate an appeal for most claims, you must submit a request for an appeal within 180 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage

determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 48 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited,



we will respond orally with a decision within 48 hours, followed up in writing.

Independent Review Procedure

Any external review procedure available under the plan will apply to any adverse determination regarding whether the plan complied with the surprise billing and cost sharing protections of the federal No Surprises Act and its implementing regulations.

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by Cigna's Physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by Cigna.

Step Therapy Appeal Procedure

You may appeal a step therapy exception determination. Cigna will comply with the following for step therapy appeal requirements:

- Standard Appeal: within thirty (30) calendar days after the receipt of the appeal request and all information necessary to complete it.
- Expedited Appeal: within forty-eight (48) hours after receipt of the appeal request and all the information necessary to complete it.

Assistance from the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.



Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action.

Appeal to the State of Tennessee

You have the right to contact the Department of Commerce and Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37423
800-342-4029

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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.

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 the covered person's choice of:

- a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or
- a colonoscopy performed every 10 years.

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.

The Schedule

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

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 other facility as required by Texas law, or by an Out-of-Network provider in an In-Network Hospital, is the amount based on the usual and customary rate as defined by Texas law or 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, except as described in the Surprise Bill provision. 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 Surprise Bill Charges – for services rendered in Texas

Contact Cigna Customer Service at the phone number on your ID card if you inadvertently receive services (i.e., an Out-of-Network surprise bill):

- from an Out-of-Network provider as part of covered services rendered in an In-Network facility; or
- from an Out-of-Network diagnostic imaging or laboratory service provider, when services are performed in connection with In-Network services.

The allowable amount used to determine the Plan’s benefit payment is an amount based on the usual and customary rate as defined by Texas law or the amount agreed to by the Out-of-Network provider and Cigna. You are responsible for applicable cost-sharing amounts (any deductible, copay or coinsurance). Out-of-Network providers who are subject to Texas law may not attempt to collect from you any amount in excess of the allowable amount.

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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 Schedule is amended to indicate the following:

Cardiovascular Disease Screening

Charges for Cardiovascular Disease Screenings are payable at 100%, with one screening every 5 years, not to exceed \$200.

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

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

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

SCHEDTX-ET

Covered Expenses

- charges made for an annual screening by all forms of low dose mammography for the presence of occult breast cancer for women 35 years of age and older. Coverage will also be provided for a diagnostic mammogram. Diagnostic imaging means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate: a) a subjective or objective abnormality detected by a Physician or patient in a breast; b) an abnormality seen by a Physician on a screening mammogram; c) an abnormality previously identified by a Physician as probably benign in a breast for which follow-up imaging is recommended by a Physician; or d) 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 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, neuropsychological, 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 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 a drug that has been prescribed for the treatment of a covered chronic, disabling or life-threatening illness, provided that drug is Food and Drug (FDA) approved for at least one indication and is recognized for treatment in one of the standard reference compendia (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. Coverage will also be provided for any medical services necessary to administer the drug.

- 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 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, so long as the diagnosis occurred prior to the insured's 10th birthday. 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 Hospital Confinement of a mother and her newborn child for 48 hours following an uncomplicated vaginal delivery, or for 96 hours following an uncomplicated cesarean delivery. After consulting with her attending Physician the mother may request an earlier discharge if it is determined that less time is needed for recovery. If Medical Necessity requires the mother and/or newborn to remain confined for longer than 48 hours, the additional confinement will be covered. If the mother is discharged prior to the 48 or 96 hours described above, a postpartum home care visit will be covered. Postpartum 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.
- 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 diagnostic and surgical treatment 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; and a prostate-specific antigen (PSA) test for a man who is at least 50 years of age and asymptomatic or at least 40 years of age with a family history of prostate cancer, or another prostate 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 your 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.

Hearing Aids and Cochlear Implants for Children

Coverage will be provided for Medically Necessary 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 audilogically necessary).

Serious Mental Illness

Charges for treatment of Serious Mental Illness at the same rate as for other illnesses. A Serious Mental Illness is defined as: schizophrenia, paranoid and other psychotic disorders, bipolar disorders (hypomanic, manic, depressive, and mixed), major depressive disorders (single episode or recurrent), schizoaffective disorders (bipolar or depressive), obsessive-compulsive disorders, and depression in childhood or adolescence.

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, Supplies and Training:

- blood glucose monitors, including those designed to be used by the legally blind;
- 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;
- podiatric appliances, including up to two pair of therapeutic footwear per year, for the prevention of complications associated with diabetes;
- glucagon emergency kits.

If determined as Medically Necessary by a treating Physician, new or improved treatment and monitoring equipment or supplies (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 a licensed healthcare 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 funduscopy 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.

Charges made for routine patient care costs in connection with a phase I, phase II, phase III or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection or treatment of a life threatening disease or condition and is approved by: the Centers for Disease Control and Prevention of the United States Department of Health and Human Services; the National Institutes of Health; the United States Food and Drug Administration; the United States Department of Defense; the United States Department of Veterans Affairs; or an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

Routine patient care costs means the costs of any Medically Necessary health care service for which benefits are provided under a health benefit plan, without regard to whether the enrollee is participating in a clinical trial. Routine patient care costs do not include: the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial; the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a

clinical trial; the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; a cost associated with managing a clinical trial; or the cost of a health care service that is specifically excluded from coverage under a health benefit plan.

- charges for a service provided through Telemedicine or Telehealth are covered.

These benefits may not be subject to a greater Deductible, Copayment, or Coinsurance than for the same service under this plan provided through a face-to-face consultation. Such coverage will not include charges for a Telemedicine medical service or a Telehealth service provided by an audio-only telephone consultation, a text-only e-mail message or a facsimile transmission.

The term 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.

The term 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.

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.

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 or Crisis Stabilization Unit 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 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.

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

Mental Health Residential Treatment Center for Children and Adolescents means a Mental Health Residential Treatment Center, as defined in this section, which specializes in the treatment of children and adolescents.

Psychiatric Day Treatment Facility means a Mental Health Residential Treatment Center that provides Outpatient Mental Health Services, as defined in this section.

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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.

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The Schedule

The pharmacy Schedule is amended to indicate the following:

Oral Chemotherapy Medication

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

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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.

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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.

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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.

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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.

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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:

- the following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupuncture; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- non-medical counseling 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, driving safety courses.

- 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-EXC534

01-23
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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 pursuing any subrogation or recovery rights by providing requested information.

HC-SUB84

10-16

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

Certificate Rider

Policyholder: Pla-Fit Franchise LLC

Rider Eligibility: Each Employee

Policy Number: 3345932

Effective Date of This Rider: 01/01/2025

This rider forms a part of the certificate issued to you by Cigna describing the main features of the policy specified

above. This rider is subject to all terms of the policy except those specifically changed by this rider.

The provisions set forth in this rider comply with legislative requirements of the Texas Insurance Code regarding Elective Abortion in the state of Texas.

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

Elective Abortion		
Elective Abortion means an abortion for any reason other than a spontaneous abortion or to prevent the death or a serious risk of substantial impairment of a major bodily function of the female upon whom the abortion is performed.		
Physician's Office Visits	Covered same as Physician's Services - Surgery Performed in the Physician's Office benefit	Covered same as Physician's Services - Surgery Performed in the Physician's Office benefit
Inpatient Facility	Covered same as Inpatient Hospital benefit	Covered same as Inpatient Hospital benefit
Outpatient Facility	Covered same as Outpatient Facility Service benefit	Covered same as Outpatient Facility Service benefit
Physician's Services	Covered same as Inpatient Hospital Professional Services benefit or Outpatient Professional Services benefit, as appropriate	Covered same as Inpatient Hospital Professional Services benefit or Outpatient Professional Services benefit, as appropriate

The Covered Expenses provision in your certificate is amended to include the following provision:

- charges made for elective abortions (that is, an abortion for any reason other than a spontaneous abortion or to prevent the death or a serious risk of substantial impairment of a major bodily function of the female upon whom the abortion is performed).



CIGNA HEALTH AND LIFE INSURANCE COMPANY

Geneva Cambell Brown, Corporate Secretary

Bryan Holgerson, President

Wilbur E. Parsell, Registrar

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

ACCEPTED BY:

Policyholder Representative

Title

Date

HC-RDR124

01-18

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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.

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

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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.

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

HC-DFS1840

01-23
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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
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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	GPPO¹	PPO²
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
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Prior Authorization/Pre-Authorized

Prior Authorization is not required for Emergency Services.

HC-PRA1

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V7-ET

Covered Expenses

- charges made by a Physician, Naturopath or a Psychologist for professional services.

HC-COV1474

01-24
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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.
- 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.

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

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

HC-COV1132

01-21
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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.

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.

You may obtain a supply of prescribed contraceptives intended to last over a 12-month period, which may be dispensed all at once or over the course of the 12 months at the discretion of your provider.



If the following text “Specialty Clinical Days’ Supply... prescription drug therapy.” is included in your certificate, it does not apply to you.

Specialty Clinical Days’ Supply

Specialty clinical days’ supply is designed to improve customer adherence and satisfaction while reducing the waste of Specialty Prescription Drug Products resulting from changes in prescription drug therapy. Specialty clinical days’ supply uses clinical guidelines, customer experience, financial considerations, and Cigna’s home delivery pharmacy expertise to establish an optimum maximum days’ supply for each fill of a Specialty Prescription Drug Product. The maximum days’ supply of a Specialty Prescription Drug Product, dispensed by a Cigna designated specialty pharmacy, may be limited to less than the home delivery days’ supply maximum indicated in The Schedule depending on the drug, condition, and demonstrated patient stability on prescription drug therapy.

HC-PHR514

04-21
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-EXC578

10-23
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

Medically Necessary/Medical Necessity

"Medically-necessary care" including diagnostic testing, preventive services and aftercare that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. Medically-necessary care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical-condition, and must be informed by the unique needs of each individual patient and each presenting situation, and

- help restore or maintain the member's health; or
- prevent deterioration of or palliate the member's condition; or
- prevent the reasonably likely onset of a health problem or detect an incipient problem.

HC-DFS1333

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

CERTIFICATE RIDER – Virginia Residents

Rider Eligibility: Each Employee who is located in Virginia

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

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

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

HC-ETVARDR

How To File Your Claim

Payment of Claim

All benefits payable under the Policy are payable within 40 days of receipt of proof of loss. All or any portion of any benefits may be paid to the health care services provider.

HC-CLM8

01-11

V2-ET

Eligibility - Effective Date

Exception to Late Entrant Definition

A person will not be considered a Late Entrant when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to other available coverage; Employer contributions toward the other coverage have been terminated; he no longer qualifies in an eligible class for prior coverage; or if such prior coverage was continuation coverage and the continuation period has been exhausted; and he enrolls for this coverage within 30 days after losing or exhausting prior

coverage; or if he is a Dependent spouse or minor child enrolled due to a court order within 31 days after the order is issued.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption or foster care, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective, on the date of marriage, birth, adoption, or placement for adoption or foster care.

Prescription Drug Benefits

Limitations

Step Therapy

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

If your treating health care provider submits a request for a step therapy exception determination, the request must state the circumstance that qualifies for a step therapy exception.

We will respond to the exception request with our decision within three (3) business days of receipt of the exception request.

In cases where emergency circumstances exist, we will respond with our decision within 24 hours of receipt of an exception request.

If we grant an exception request, we will authorize coverage for the Prescription Drug Product.

You may request an appeal of any step therapy exception denial by following the appeals process.

Termination of Insurance

Reinstatement of Medical Insurance

If your Medical Insurance ceases because of active duty in: the United States Armed Forces; the Reserves of the United States Armed Forces; or the National Guard, the insurance for you and your Dependents will be reinstated after your deactivation provided you apply for reinstatement and you are otherwise eligible.



Such reinstatement will be without the application of: a new waiting period. The remainder of any waiting period which existed prior to interruption of coverage may still be applied.

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

CERTIFICATE RIDER – Washington Residents

Rider Eligibility: Each Employee who is located in Washington

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

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

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

HC-ETWARDR

Notice

Coordination of Benefits Included – See Table of Contents for Location of Coordination of Benefits Section. Your Benefits may be affected by other Insurance.

HC-CER1

02-16
V11-ET

Customer Service

HIPAA Privacy Statement

Your privacy is important to us. The following website explains how we collect and protect information about you:

www.cigna.com/privacyinformation

You may also request copies of this information by contacting customer service at the number shown on your ID card

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

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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 have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Insurers are required to tell you, via their websites or on request, which providers, hospitals, and facilities are in their networks. Hospitals, surgical facilities, and providers must tell you which provider networks they participate in on their website or on request.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition, mental health or substance use disorder condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes care you receive in a hospital and in facilities that provide crisis services to people experiencing a mental health or substance use disorder emergency. You can't be balance billed for these emergency services, including services you may get after you're in stable condition.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most these providers may bill you is your plan's in-network cost-sharing amount.

You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When can you be asked to waive your protections from balance billing:

Health care providers, including hospitals and air ambulance providers, can never require you to give up your protections from balance billing.

If you have coverage through a self-funded group health plan, in some limited situations, a provider can ask you to consent to waive your balance billing protections, but you are never required to give your consent. Please contact your employer or health plan for more information.



When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may file a complaint with the federal government at <https://www.cms.gov/nosurprises/consumers> or by calling 1-800-985-3059; and/or file a complaint with the Washington State Office of the Insurance Commissioner at their website www.insurance.wa.gov or by calling 1-800-562-6900.

Visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.

Visit the Office of the Insurance Commissioner Balance Billing Protection Act website for more information about your rights under Washington state law.

HC-NOT132

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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

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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
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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 31 days, you must elect Dependent Medical Insurance for your newborn child within the 60 day enrollment period which begins on the first day of birth. If Dependent Medical Insurance is not elected within the 60 day enrollment period, you may be required to wait until the next plan enrollment period to enroll the child for coverage under the plan. Coverage shall include, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth.

HC-ELG305

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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

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Certification Requirements - Out-of-Network For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

If your request for Experimental and Investigational treatment is denied, Cigna will notify you in writing within 20 working days. This review period will be extended beyond 20 working days only if you provide your informed written consent to Cigna.

PAC will not be required for mental health treatment rendered by a state Hospital when you or your Dependent are involuntarily committed.

We will not retroactively deny coverage for:

- emergency and non-emergency care that had Prior Authorization under the plan's written policies at the time the care was rendered; or
- care based on standards and protocols not communicated within a sufficient time for your Physician, health care provider or facility to modify care.

Pre-Admission Certification is not required for withdrawal management services or inpatient or residential Substance Use Disorder treatment in a behavioral health agency specializing in addiction and withdrawal management, which is licensed or certified by the State of Washington. A review for Medical Necessity may later be required after two business days for inpatient or residential treatment at a behavioral health agency and after three days at a behavioral health agency for withdrawal management services.

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

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

Medical Benefits

Continuity of Care

- There may be instances in which your Participating Provider becomes unaffiliated with Cigna's network. In such cases you will be notified and provided assistance with selecting a new provider.
- However, under special medical circumstances, you may be able to continue seeing your provider, even though he or she is no longer affiliated with Cigna. This allows continued, uninterrupted care until safe transfer to a Participating Provider can be arranged. If you are undergoing an active course of treatment for an acute or chronic condition and continued treatment is Medically Necessary, you may be eligible to receive continuing care from the non-Participating Provider for at least 60 days or until the end of the next open enrollment period, subject to the treating provider's agreement. You may also be eligible to receive continuing care if you are in your second or third trimester of pregnancy. In this case, continued care may be extended through your delivery and include a period of postpartum care.
- You may request continuity of care from Cigna after your Participating Provider's termination. Continuity of care must be Medically Necessary and approved in advance by Cigna. Your provider must agree to accept our

reimbursement rate and to abide by Cigna's policies and procedures and quality assurance requirements. Continuity of care will cease if your treatment is successfully transitioned to a Participating Provider.

- There may be circumstances when continued care by a provider no longer participating in Cigna's network will not be available, such as when the provider loses his or her license, is terminated for cause, or retires.

HC-PAC126

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Covered Expenses

- charges for ground Ambulance transports to behavioral health emergency services providers.
- charges made in connection with mammograms for breast cancer screening if prescribed by a Physician, an advanced registered nurse practitioner or a physician assistant.
- charges made for screening prostate-specific antigen (PSA) test.
- charges 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 abortions.
- 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-COV1630

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The Schedule

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

Abortion Drugs

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

SCHEDPHARM90-waet3

The Schedule

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

Epinephrine Auto-Injector Device

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

SCHEDPHARM90-waet4

The Schedule

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

Prescription Asthma Inhaler

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

SCHEDPHARM90-waet5

The Schedule

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

HIV Post-Exposure Prophylactic Drugs

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

SCHEDPHARM90-waet6

The Schedule

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

Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your Deductible and counts toward your Out-of-Pocket Maximum.

Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your Deductible and counts towards 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.

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

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

An urgent care review request refers to any request for approval of care or treatment where the passage of time could seriously jeopardize the life or health of the patient, seriously jeopardize the patient's ability to regain maximum function or, in the opinion of a provider with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

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

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

When Cigna establishes new limitations on coverage of a Prescription Drug Product, Cigna will ensure that prior notice of the change will be provided as soon as is reasonably

possible to insureds who filled a prescription for the drug within the prior three months.

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

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

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P&T Committee clinically evaluates the Prescription Drug for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Drug Substitution

FDA approved Prescribed Drug Products that are the sole prescription drug available for a covered medical condition will be covered. Coverage for a non-Prescription Drug List Prescription Drug Product will not be excluded if the only Prescription Drug List drug available for your covered condition is one that you cannot tolerate or that is not clinically efficacious for you.

Supply Limits

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

You may obtain a twelve-month refill of covered contraceptive drugs if prescribed by your provider or you may request a smaller supply. If available, you may receive the contraceptives on site at the doctor's office. During the last quarter of the plan year the refill amount may be limited if a twelve-month supply of the contraceptive drug has already been dispensed during the plan year.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the

amount dispensed per month's supply, or may require that a minimum amount be dispensed.

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

HC-PHR539

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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 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.

HC-PHR818

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

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

- 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.

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

scientific literature or guidelines. Charges for health care services, supplies, or medications when billed for conditions or diagnoses that are not covered or reimbursable under the coverage policies maintained by Cigna or the Review Organization.

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

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

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Payment of Benefits

Medical

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person or facility to whom it was made; or offset the amount of that overpayment from a future claim payment.



Except in the case of fraud, when an overpayment has been made by Cigna to a healthcare provider, Cigna will not have the right to:

- (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless the request is made in writing to the provider within twenty-four months after the date that the payment was made; or
- (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why Cigna believes the provider owes the refund. If a provider fails to contest the request in writing to Cigna within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

Cigna will not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim:

- (a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within thirty months after the date that the payment was made; or
- (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why Cigna believes the provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If a provider fails to contest the request in writing to Cigna within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

Cigna may at any time request a refund from a health care provider of a payment previously made to satisfy a claim if:

- (a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and
- (b) Cigna is unable to recover directly from the third party because the third party has either already paid or will pay the provider for the health services covered by the claim.

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Termination of Insurance

Continuation of Insurance During Strike, Lockout or Other Labor Dispute

If your Medical Insurance will end due to a strike, lockout, or other labor dispute, under Washington law, you may elect to continue medical benefits for yourself and your insured Dependents. Your Employer will notify you of your right to

continue your medical coverage. This notice will specify the amount of your premium payment, when your premium payments are due and the address to mail your payment. You must complete the application included with the notice and return it to your Employer with the required premium.

Medical benefits for your continued coverage will be those in effect on the day before the labor dispute began.

Your medical coverage will be continued until the earlier of:

- the last day for which you have made any required contribution for the insurance;
- the date the group policy terminates;
- the end of a period 6 months from the date your continued coverage began.

You must notify your Employer in writing if you become eligible for other group medical coverage prior to the end of the continuation period.

HC-TRM109

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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 you receive. That is why we have established a process for addressing your concerns and solving your problems.

You can start the appeals process at any time.

You are entitled, upon written request, to seek an immediate expedited external review simultaneously, during an initial request and/or the appeal process when the appeal involves concurrent inpatient stays or ongoing outpatient services.

Start with Customer Service

We are here to listen and help. If you have a Grievance, you can call our toll-free number found on your Benefit Identification card or in the “Important Notices” section of this certificate and explain your concern to one of our Customer Service representatives.

A Grievance is a written complaint submitted by or on behalf of an insured person regarding service delivery issues other than denial of payment for medical services or non-provision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff



attitude or demeanor, or dissatisfaction with service provided by the health carrier.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions involving Adverse Determinations and Non-certification. An Adverse Determination or Non-certification coverage decision is a decision by Cigna to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits including the admission to or continued stay in a facility. It also includes a rescission of coverage.

To initiate an appeal for most claims, you must submit a request for an appeal within one year of receipt of a denial notice.

If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable to or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, the "Important Notices" section of this certificate, explanation of benefits or claim form. We will acknowledge in writing, within seventy-two hours, that we have received your request.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 14 calendar days after we receive an appeal for a required pre service or Concurrent Care Coverage Determination (decision). We will respond within 14 calendar days after we receive an appeal for a post service coverage determination. If more time or information is needed to make the determination, we will notify you in writing, in this case, the decision will be made within 30 days. For appeals based

on experimental treatment exclusions, the decision will be made within 20 days. Any extension beyond 20 days will require your informed written consent.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services.

If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level one appeal would be detrimental to your medical condition.

Your treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

If the appeal involves a coverage decision based on issues of Medical Necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician Reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician Reviewer. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was (a) not involved in any previous decision related to your appeal, and (b) not a subordinate of previous decision makers. Provide all relevant documentation with your second-level appeal request.

For required pre service and Concurrent Care Coverage Determinations, Cigna's review will be completed within 14 calendar days. For post service claims, Cigna's review will be completed within 14 calendar days.

We may request additional information if needed to complete the review. If more time or information is needed to make the determination, we will notify you in writing. Any extension will not delay the decision beyond 30 days without your informed written consent. In the case of appeals based on experimental treatment exclusions, your informed written consent is needed for any extension beyond 20 days. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.



You will be notified in writing of Cigna's decision within five working days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non authorization of an admission or continuing inpatient Hospital stay. Your treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing no later than 72 hours after the date of the decision.

Experimental and Investigational Therapies Appeals

If your request for Experimental and Investigational treatment is denied, Cigna will notify you in writing within 20 working days. This review period will be extended beyond 20 working days only if you provide your informed written consent to Cigna.

Independent Review Procedure

Any external review procedure available under the plan will apply to any adverse determination regarding whether the plan complied with the surprise billing and cost sharing protections of the federal No Surprises Act and its implementing regulations.

If you are not fully satisfied with the decision of Cigna's internal appeals process regarding your issue or if Cigna has exceeded the timelines without good cause and without reaching a decision, you may request that your appeal be referred to an Independent Review Organization. You may also request that your appeal be referred to an Independent Review Organization if Cigna does not handle your level one or level two appeal within the timeframe described for the level one or level two appeal. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level two appeal review denial. Within one day of selecting the IRO, Cigna will notify you of the name of the Independent Review Organization and its contact information.

Cigna will then forward the file to the Independent Review Organization. Cigna will provide to the Independent Review Organization, no later than the 3rd business day after the date Cigna receives a request for review, all relevant clinical review criteria used by Cigna and other relevant medical, scientific, and cost-effectiveness evidence, the attending or ordering provider's recommendations, and a copy of the terms and conditions of coverage under the relevant health plan.

Cigna will also make available to you and to any provider acting on your behalf, all materials provided to the Independent Review Organization.

When you request an appeal and the dispute involves Cigna's decision to modify, reduce or terminate an otherwise covered health service that you are receiving at the time request is submitted, and Cigna's decision is based upon a finding that the health service, or level of health services is no longer Medically Necessary or appropriate, Cigna will continue to provide the health care service at your request until a determination is made. If the determination affirms Cigna's decision, you may be responsible for the cost of the continued health service.

The Independent Review Organization will render an opinion not later than the earlier of the 15th day after the date The Independent Review Organization receives the information necessary to make a determination, or the 20th day after the date The Independent Review Organization receives the request that the determination be made. In exceptional circumstances, when The Independent Review Organization has not obtained the necessary information, a determination may be made by the 25th day after The Independent Review Organization received the request for determination. In cases of a condition that could seriously jeopardize a participant's health or ability to regain maximum function, a decision will be rendered not later than the earlier of: 72 hours after The Independent Review Organization receives necessary information, or the 8th day after The Independent Review Organization receives the request for determination.

If the treating Physician determines that a delay could jeopardize the covered person's health or ability to regain maximum function, Cigna will presume the need for expedited review, and treat the review request as such.

Contacting the State of Washington

You have the right to contact the Office of the Insurance Commissioner for assistance at any time. The U.S. Department of Health and Human Services has designated the Washington State Office of the Insurance Commissioner's Consumer Protection Division as the current health insurance consumer assistance office or ombudsman.



You have the right to contact the Office of the Insurance Commissioner for assistance at any time. The Commissioner may be contacted at the following telephone number:

Washington State Office of the Insurance Commissioner
Consumer Protection Division
OIC Consumer Assistance Hotline 1-800-562-6900

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: availability, upon request, of the diagnosis and treatment codes, and their meanings (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; (3) reference to the specific plan provisions on which the determination is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and (7) information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process. A final notice of an adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or

guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action.

However, no action may be brought at all unless brought within three years after a claim is submitted for In-Network services, or within three years after proof of claim is required under the plan for Out-of-Network services.

HC-APL515

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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

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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

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Domestic Partner

A Domestic Partner is defined as a person who has a valid domestic partner registration in Washington.

HC-DFS1608

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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

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Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets, injection aids, test strips for glucose monitors, visual blood sugar reading and urine testing strips, prescriptive oral agents for controlling blood sugar levels, glucogen emergency kits), needles and syringes for injectables

covered under the pharmacy plan, and spacers for use with oral inhalers.

HC-DFS68

V7-ET

Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)

Although federal law does not extend FMLA rights to Domestic Partners, this plan will extend these same continuation benefits to Domestic Partners (and their children if not legal children of the Employee) to the same extent they are provided to spouses and legal children of the Employee.

HC-FED99

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V3-ET

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-Existing Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.



If your coverage under this Plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

Although federal law does not extend USERRA rights to Domestic Partners, this Plan will extend these same continuation benefits to Domestic Partners (and their children if not legal children of the Employee) to the same extent they are provided to spouses and legal children of the Employee.

HC-FED100

01-24
V2-ET

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-ETWDR

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

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.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Cigna has a one step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. However, if Cigna reduces or terminates coverage (except where the reduction or termination is due to a plan amendment or termination) for an ongoing course of treatment that Cigna previously approved, and the reduction or termination in coverage will occur before the end of the period of time or number of treatments that Cigna approved, then to initiate an appeal you must submit a request for an appeal of that reduction or termination in coverage within 30 days of receipt of the denial notice. If you appeal timely a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

Most requests for an appeal will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may present your situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received your request and schedule a Committee review. A written notification, including the time and place of the meeting, will be sent to you at least seven calendar days before the meeting. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.



You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Assistance from the State of Wisconsin

You have the right to contact the Wisconsin Office of the Commissioner of Insurance for assistance at any time. The Wisconsin Commissioner of Insurance may be contacted at the following address and telephone number:

Office of the Commissioner of Insurance
121 West Wilson Street
Madison, WI 53702
608-266-0103 (In Madison)
800-236-8517 (Outside Madison)

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeals procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the

course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the appeal process.

HC-APL328

01-19
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



Home Office: Bloomfield, Connecticut

Mailing Address: 900 Cottage Grove Road, Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

No. CR7MN003-2

Policyholder: Pla-Fit Franchise LLC

Rider Eligibility: Each Employee who resides in Massachusetts

Policy No. or Nos. 3345932-OAP

Effective Date: January 1, 2025

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

A handwritten signature in black ink, appearing to read "Geneva Cambell Brown".

Geneva Cambell Brown, Corporate Secretary

HC-RDR1

04-10
V11



The pages in your certificate coded **HC-MANCR1V1** and **HC-MANCR2 V14** are replaced by the pages coded **HC-MANCR1V1** and **HC-MANCR2 V15** attached to this certificate rider.

Notice To Massachusetts Residents



This Open Access Plus Medical Benefits health plan, alone, **does not meet Minimum Creditable Coverage standards and will not satisfy** the individual mandate that you have health insurance. For additional information, please see the section “Massachusetts Requirement to Purchase Health Insurance,” immediately preceding the Schedule.

HC-MANCR1V1



Massachusetts Requirement To Purchase Health Insurance:

This Open Access Plus Medical Benefits health plan, alone, **does not meet Minimum Creditable Coverage standards** that are effective January 1, 2025 as part of the Massachusetts Health Care Reform Law because:

- The In-Network Deductible is more than \$2,950 for an individual and/or \$5,900 for a family.

If you purchase this health plan only, you **will not satisfy** the statutory requirement that you have health insurance meeting these standards.

If this health plan is offered to you through your place of employment, contact your Employer or other plan sponsor to determine if it offers other health plan options that meet Minimum Creditable Coverage standards. Your Employer or other plan-sponsor also may offer supplemental plans you can add to this insured health plan in order to meet Minimum Creditable Coverage.

If this health plan is not offered to you through your place of employment and you want to learn about other health plan options available to individuals, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi, or the Connector by calling 1-877-MA-ENROLL or visiting its website at www.mahealthconnector.org.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2025. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

HC-MANCR2

01-25
V15



Home Office: Bloomfield, Connecticut

Mailing Address: 900 Cottage Grove Road, Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

No. CR7MN002-2

CR7MN005-2

Policyholder: Pla-Fit Franchise LLC

Rider Eligibility: Each Employee who resides in Massachusetts

Policy No. or Nos. 3345932-HSF/HSI, HR2

Effective Date: January 1, 2025

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

A handwritten signature in black ink, appearing to read "Geneva Cambell Brown".

Geneva Cambell Brown, Corporate Secretary

HC-RDR1

04-10
V11



The pages in your certificate coded **HC-MACR1V1** and **HC-MACR2 V11** are replaced by the pages coded **HC-MACR1V1** and **HC-MACR2 V12** attached to this certificate rider.

Notice To Massachusetts Residents



This Open Access Plus Medical Benefits health plan **meets Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. For additional information, please see the section “Massachusetts Requirement to Purchase Health Insurance,” immediately preceding the Schedule.

HC-MACR1V1



Massachusetts Requirement To Purchase Health Insurance:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This Open Access Plus Medical Benefits health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2025 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2025. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

HC-MACR2

01-25

V12