City of Fort Lauderdale

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2026

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This document printed in December, 2025 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

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

CERTIFICATE RIDER

Policyholder: City of Fort Lauderdale
Rider Eligibility: Each Employee as noted within this certificate rider
Policy No. or Nos.: 3335139
Effective Date: January 1, 2026

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

IMPORTANT INFORMATION

For Residents of States other than the State of Florida:

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

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

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

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

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

Alicia M. Morrow, ESQ, Corporate Secretary

HC-ETRDR

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

CERTIFICATE RIDER – Arkansas Residents

Rider Eligibility: Each Employee who is located in Arkansas

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

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

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

HC-ETARRDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

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

Exception for Adopted Children

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

If you do not elect to insure your adopted child within such 90 days, or if your petition for adoption is dismissed or denied, no benefits for expenses incurred beyond the 90th day following placement or filing of the petition to adopt, whichever is later, will be payable.

HC-ELG241 01-19

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The Schedule

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

Mammograms, PSA, Pap Smear, Colorectal Cancer Screenings

In-Network Preventive Care Related Services (i.e. "routine" services) will be covered at "No charge".

The following note is hereby added to Diagnostic Related Services (i.e. "non-routine" services):

Note:
A follow-up colonoscopy is not subject to a cost share requirement if services are performed In-Network.

SCHED AR ET3

The Schedule

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

SCHED AR ET4

Covered Expenses

- charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided, including charges for Ambulance services to treat an individual in place, triage, or triage and transport to an alternative destination if the ambulance service is

coordinating care through telemedicine for a medical-based complaint or a behavioral-based compliant.

- charges for screening for hepatitis C during pregnancy; not subject to Copay or Deductible.
- charges for the treatment of newborn children for congenital defects, spinal muscular atrophy, premature birth, and tests for hypothyroidism, phenylketonuria and galactosemia and tests for sickle cell anemia and all other genetic disorders for which screening is performed by or for the State of Arkansas. Coverage will also include routine nursery care and pediatric charges for well newborn children for the earlier of 5 days in a Hospital nursery, or until the mother is discharged from the Hospital.
- charges made for anesthesia, hospitalization services or ambulatory surgical facility charges performed in connection with dental procedures when such services are required to effectively perform the procedures and the patient is:
  - under seven years of age and it is determined by two dentists that treatment in a Hospital or ambulatory surgical center is required without delay due to a significantly complex dental condition; or
  - a person with a serious diagnosed mental or physical condition; or
  - a person with a significant behavioral problem as determined by their Physician.
- charges for colorectal cancer examinations and laboratory tests for individuals who:
  - are 45 years of age or older.
  - less than 45 years of age and at high risk for colorectal cancer. Individuals defined to be at “high risk” include:
    - the presence of one (1) or more adenomatous polyps on a previous colonoscopy, or flexible sigmoidoscopy;
    - have a family history of colorectal cancer;
    - have genetic alterations of hereditary nonpolyposis;
    - have colon cancer or familial adenomatous polyposis;
    - a personal history of colorectal cancer, ulcerative colitis, or Crohn’s disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and
    - any additional or expanded definition of "high risk" as recognized by medical science and determined by the Secretary of the Department of Health in consultation with the University of Arkansas for Medical Sciences and consistent with guidelines issued by the United States Preventive Services Task Force.
  - individuals experiencing the following symptoms of colorectal cancer as determined by a Physician: bleeding from the rectum or blood in the stool; or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

  The colorectal screening shall involve an examination of the entire colon, including:
  - all examinations, lab tests, or preventive screening tests assigned either a grade of "A" or a grade of "B" by the United States Preventive Services Task Force.
  - any additional medically recognized screening tests determined by the United States Preventive Services Task Force for colorectal cancer.

    Benefits for follow-up screening shall be limited to the following guidelines for the management or subsequent need for follow-up colonoscopy:
    - a colonoscopy performed as a result of a positive result on a non-colonoscopy preventive screening test; or
    - any additional non-colonoscopy preventive screening tests for colorectal cancer required by the Secretary of the Department of Health in consultation with the University of Arkansas for Medical Sciences and consistent with guidelines issued by the United States Preventive Services Task Force.
- charges for prostate cancer examinations and laboratory tests once a year for non-symptomatic men who are forty years of age or older in accordance with the National Comprehensive Cancer Guidelines.
- expenses incurred at any of the Approximate Age Intervals shown below for a Dependent child who is age 18 or less, for charges made for Child Preventive Care Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:
  - a history;
  - physical examination;
  - development assessment;
  - anticipatory guidance;

- appropriate immunizations, which are not subject to any Copay, Coinsurance, Deductible, or dollar limit, and laboratory tests; excluding any charges for:
  - more than one visit to one provider for Child Preventive Care Services at each of the Approximate Age Intervals up to a total of 20 visits for each Dependent child;
  - services for which benefits are otherwise provided under this Covered Expenses section; and
  - services for which benefits are not payable according to the Expenses Not Covered section.

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

  Required medical care coverage includes reconstructive surgery, dental care, and vision care. Coverage for the following is included, if Medically Necessary:
  - on an annual basis:
    - sclera contact lenses, including coatings;
    - office visits;
    - an ocular impression of each eye;
    - autologous serum eye drops;
    - eye weights, either surgically and/or external eye weights in one or both eyes, as directed by an eye specialist; and
    - any additional tests or procedures that are Medically Necessary for a craniofacial patient.
  - every two (2) years, two (2) hearing aids and two (2) hearing aid molds for each ear; and
  - every four (4) years, a dehumidifier.
- charges for prescription drugs or devices approved by the United States Food and Drug Administration for use as a contraceptive. Cost share levels are the same as for other covered prescription drugs. Covered contraceptives include oral, implantable, and injectable contraceptive drugs, intrauterine devices, and prescription barrier methods for contraception.
- charges for positron emission tomography to screen for or to diagnose cancer in a patient upon the recommendation of the patient's Physician when the patient has a prior history of cancer.
- charges for a gastric pacemaker to treat gastroparesis, a neuromuscular stomach disorder in which food empties into the stomach more slowly than normal.
- charges for screening for depression of the birth mother by a healthcare professional within the first six (6) weeks of giving birth.
- charges for biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of an individual’s disease or condition to guide treatment decisions when supported by medical and scientific evidence.
- charges for screenings for behavioral health conditions and behavioral health services provided in a Hospital, outpatient clinic, Physician clinic or through telemedicine.

Pediatric Autoimmune Neuropsychiatric Disorders (PANS) (PANDAS)

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

Covered Expenses

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts.

Prostheses/prosthetic appliances and devices include, but are not limited to:

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

Orthoses and Orthotic Devices

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

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

The following are specifically excluded orthoses and orthotic devices:

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

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

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

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

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

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

The following are specifically excluded external prosthetic appliances and devices:

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

The Schedule

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

Coinsurance

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

SCHEDPHARM90-aret4

The Schedule

The Pharmacy Schedule is amended to indicate that for plans subject to the Affordable Care Act (ACA) contraceptives are covered at no cost share, when purchased from a Network or home delivery Pharmacy, if applicable. A written prescription is required. Otherwise, Contraceptive devices and oral contraceptives are payable as shown in The Schedule, unless your plan qualifies for a religious exemption.

SCHEDPHARM90-aret1

Prescription Drug Benefits

Limitations

Prior Authorization Requirements

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

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

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

Step Therapy

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

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

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

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

A request for a step therapy protocol exception shall be granted or denied within seventy-two (72) hours of receiving

the request and twenty-four (24) hours of receiving the request for urgent cases.

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

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

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

Prescription Eye Drops

Charges for early refills of prescription eye drops if:

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

HC-PHR715 01-24
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Prescription Drug Benefits

Your Payments

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

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

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

HC-PHR254 12-17
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Exclusions

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

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be either:
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing any condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.

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

reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of the prescribed indication in any one of the following: The American Hospital Formulary Service Drug Information; The National Comprehensive Cancer Network Drugs and Biologics Compendium; and The Elsevier Gold Standard's Clinical Pharmacology; or the drug has been recognized as safe and effective for treatment of that specific type of cancer in two articles from medical literature not otherwise contradicted by any one article in a similar publication; or other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the commissioner.

HC-PHR812 01-25
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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 either:

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

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

HC-EXC625 01-25
ET1

When You Have A Complaint Or An Appeal

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)

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.

HC-APL509 01-25
ET

Definitions

Dependent

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

HC-DFS1672 01-22
ET

Prescription Drug Charge

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

HC-DFS1092 12-17
ET

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

CERTIFICATE RIDER – Connecticut Residents

Rider Eligibility: Each Employee who is located in Connecticut

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

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

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

HC-ETCTRDR

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Covered Expenses incurred will be reduced by the lesser of 50% or $500 for Hospital charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will be reduced by the lesser of 50% or $500:

- Hospital charges for Room and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and

- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Certification Requirements - Out-of-Network

Covered Expenses incurred will be reduced by the lesser of 50% or $500 for charges made for any outpatient diagnostic testing or outpatient procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

HC-PAC112 02-20
ET1

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 – 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

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
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 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.

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.

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.

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 at least three 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 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 72 hours, followed up in writing.

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.

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. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if a delay would be detrimental to your condition, as determined by Cigna's Physician Reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from the facility, the review shall be completed within 72 hours.

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; 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 in federal court 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. However, no action may be brought at all unless brought within three years after a claim is submitted for In-Network services.

Assistance from the State of Georgia

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

Georgia Department of Insurance
2 Martin Luther King, Jr. Drive
Floyd Memorial Bldg, 704 West Tower
Atlanta, GA 30334
404-656-2056

HC-APL523 01-26
ET

Important Information

"If Cigna determines… required to pay." is included in the **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-IMP408 01-25
ET

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

CERTIFICATE RIDER – Indiana Residents

Rider Eligibility: Each Employee who is located in Indiana

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

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

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

HC-ETINRDR

Covered Expenses

- charges for reimbursement payments made to the Indiana First Steps program for Early Intervention Services incurred by a Dependent child enrolled in the program, from birth through age two. Payments made directly by the program will be credited toward Deductibles or Copayments.

HC-COV1604 01-25
ET3

Prescription Drug Benefits

Limitations

Prescription Eye Drops

Refill of prescription eye drops will be allowed when:

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

HC-PHR470 01-21
ET

When You Have A Complaint Or An Appeal

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

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

Step Therapy Appeal

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

- A description of the manner in which You may request a protocol exception.
- That we will make a determination concerning a protocol exception request, or an appeal of a denial of a protocol exception request, not more than in an urgent care situation, of (1) business day after receiving the request or appeal; or in a non-urgent care situation, three (3) business days after receiving the request or appeal.
- That a protocol exception will be granted if any of the following apply:
  - a preceding prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to You.
  - a preceding prescription drug is expected to be ineffective, based on both of the following:
    - the known clinical characteristics of the insured.
    - known characteristics of the preceding prescription drug, as found in sound clinical evidence.

- we have previously received:
  - a preceding prescription drug; or
  - another prescription drug that is in the same pharmacologic class or has the same mechanism of action as a preceding prescription drug; and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
- based on clinical appropriateness, a preceding prescription drug is not in the best interest of Yours because the use of the preceding prescription drug is expected to:
  - cause a significant barrier to Your adherence to or compliance with Your plan of care;
  - worsen a comorbid condition of Yours; or
  - decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.

- That when a protocol exception is granted, we will notify You and the Your health care provider of the authorization for coverage of the prescription drug that is the subject of the protocol exception.
- If a protocol exception request or an appeal of a denied protocol exception request; results in a denial of the protocol exception, we will provide You and Your health care provider notice of the denial, including a detailed, written explanation of the reason for the denial and the clinical rationale that supports the denial.
- We may request a copy of relevant documentation from Your medical record in support of a protocol exception.

HC-APL502 01-25
ET

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

CERTIFICATE RIDER – Kentucky Residents

Rider Eligibility: Each Employee who is located in Kentucky

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

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

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

HC-ETKYRDR

Important Information

Rebates and Other Payments

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

Coupons, Incentives and Other Communications

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

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

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

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

Eligibility - Effective Date

Special Enrollment for Pregnant Employees

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

The Schedule

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

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

SCHEDKY ET1

The Schedule

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

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

SCHEDKY ET2

The Schedule

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

SCHEDKY ET3

The Schedule

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

SCHEDKY ET

Covered Expenses

- charges for cochlear implants for persons diagnosed with profound hearing impairment.
- charges for Medically Necessary treatment of temporomandibular joint and craniomandibular jaw disorders.
- charges made for mammograms, diagnostic breast exams and supplemental breast exams.

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

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

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

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

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

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

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

  - used to screen for breast cancer when there is no abnormality seen or suspected; and
  - based on personal or family medical history or additional factors that may increase the individual’s risk of breast cancer.
- charges for Medically Necessary equipment, outpatient self-management training and education including medical nutrition therapy, for individuals with insulin-dependent, insulin-using, gestational, and noninsulin-using diabetes.
- charges for tobacco cessation services recommended by the U.S. Preventive Services Task Force, including individual, group, and telephone counseling, and any combination thereof.
- charges for colorectal cancer examinations and laboratory tests that are administered at a frequency identified in the most recent version of the American Cancer Society guidelines. Includes screening, labs and removal of polyps related to a preventive Colonoscopy. The covered individual shall be 45 years of age or older or less than 45 years of age and at high risk for colorectal cancer.
- charges for biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of an individual’s disease or condition to guide treatment decisions when supported by medical and scientific evidence.
- charges made for the diagnosis and treatment of autism spectrum disorders.
- charges for maternity coverage including for Dependents, regardless of age. Coverage includes maternity care associated with pregnancy, childbirth and postpartum care; labor and delivery; breastfeeding services and supplies required under Federal law; and inpatient care for the mother and newborn child for at least 48 hours of inpatient care after a vaginal delivery and at least 96 hours of care after a cesarean section. Any decision to shorten the stay must be made by the Physician in consultation with the mother. If the mother and newborn are discharged earlier than the 48/96 hours, at least one home health care visit will be covered, which includes the collection of an adequate sample for hereditary and metabolic newborn screening. Additional home health care visits may be covered if Medically Necessary. If the mother and newborn receive the

full 48/96 hours of inpatient hospital stay after delivery, home health care visits are not required to be covered. Coverage also includes in-home programs for pregnant and postpartum women; and telehealth services related to care associated with pregnancy, childbirth and postpartum care. 'In-home program' means a program for the treatment of substance use disorder which is accessed through telehealth or digital health services.

Genetic Testing for Cancer Risk

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

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

Telehealth

Dedicated Telehealth Providers

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

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

Telehealth Physician Services

A mode of delivering healthcare services through the use of telecommunication technologies, including synchronous and asynchronous technology, remote patient monitoring technology, and audio-only encounters, by a health care provider to a patient or to another health care provider at a different location.

Telehealth shall not include:

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

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

Enteral Nutrition

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

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

Coverage also includes:

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

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

syndrome; Carbamoyl phosphate synthetase deficiency; Ornithine carbamoyl transferase deficiency; Citrullinemia; Argininosuccinic aciduria; Methylmalonic acidemia; and Arginine Mia.

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

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

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

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

The Schedule

Oral Chemotherapy Medication

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

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

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

SCHEDPHARM90-kyet

Prescription Drug Benefits

Limitations

Prior Authorization

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

Prescription Eye Drops

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

Supply Limit Exceptions

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

Your Payments

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

Deductible

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

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

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

Copayment

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

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

Coinsurance

Your plan requires that you pay a Coinsurance amount 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 Coinsurance requirement will be the lowest of the following amounts:

- the amount that results from applying the applicable Coinsurance percentage set forth in The Schedule to the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

Payments

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

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

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

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

Exclusions

- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications, such as smoking cessation medications, or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law, or unless covered under the Enteral Nutrition benefit in the Covered Expenses section.

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

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

- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include: bandages

and other disposable medical supplies, skin preparations, except as specified in the “Home Health Care Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.

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

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)
P.O. Box 188011
Chattanooga, TN 37422

You may also initiate an appeal when Cigna has not made and provided written notice of an initial utilization review determination within allowable time frames. 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.

Internal Appeals

You, an authorized person, or a provider, acting on your behalf, may request an internal appeal if you are dissatisfied with the initial Medical Necessity or clinical appropriateness decision or a Coverage Denial decision, or we have failed to make and communicate in writing an initial Medical Necessity or clinical appropriateness determination within allowable time frames.

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.

Under federal law, you are allowed up to four (4) months after the date of receipt of a notice of adverse determination or final adverse determination to file a request for external review.

Step Therapy Exception Process

You, an authorized person, or a provider, acting on your behalf, may request an internal appeal of a step therapy exception denial. A step therapy exception request or internal appeal will be granted if all required information to process the request has been provided and:

- the required prescription drug is contraindicated or will likely cause an adverse reaction by physical or mental harm to you;
- the required prescription drug is expected to be ineffective based on your known clinical characteristics and the prescription drug regimen;
- the required prescription drug is not in your best interest because the use of it is expected to cause a significant

barrier to compliance with your plan of care; worsen your comorbid condition; or decrease your ability to achieve or maintain reasonable functional ability in performing daily activities;

- you have tried the required prescription drug or another prescription drug in the same pharmacological class or with the same mechanism of action as the required drug while on your current or immediately preceding health plan and such drug was discontinued due to lack of efficacy, diminished effect, or an adverse event; or
- you are stable on a prescription drug selected by your healthcare provider for the medical condition under consideration while on a current or previous health benefit plan.

Cigna must grant or deny a request for a step therapy exception determination or an appeal of a determination within 48 hours after receipt of request. If the request is not granted or denied within the timeframe, the request or appeal is deemed granted. If a request for a step therapy exception or appeal is incomplete, the prescribing provider must be notified within 48 hours of the submission of the request or appeal that the request or appeal is incomplete and what additional information that is required.

You or the provider may appeal an initial denial and may request an external review upon the denial of an appeal. If a request for a step therapy exception is granted, coverage for the prescription drug selected by the provider will be authorized. If a request for a step therapy exception is denied, you will be notified of your right to appeal or the external review process, as applicable.

The duration of any step therapy protocol will not be longer than a period of thirty (30) days if the treatment is deemed and documented as clinically ineffective by the prescribing provider. However, the step therapy protocol may be extended up to seven (7) additional days if the prescribing provider can demonstrate that the originally prescribed medication is likely to require more than thirty (30) days to provide any relief to you.

The above does not prevent:

- Cigna from requiring you to try a generic drug, a biosimilar biological product or an interchangeable biological product; or
- A health care provider from prescribing a prescription drug that is determined to be Medically Necessary.

'Step therapy exception' means a determination that a step therapy protocol should be overridden in favor of immediate coverage of the health care provider's selected prescription drug.

'Step therapy protocol' means a protocol, policy, or program that establishes the specific sequence in which prescription drugs that are for a specified medical condition and medically appropriate for a particular member are covered by an insurer or health plan.

Coverage Denial Appeals

Your appeal of a Coverage Denial determination for which a service, treatment, prescription drug, or device is specifically limited, excluded or denied under the plan will be reviewed and the decision made by someone not involved in the initial decision and not a subordinate of previous decision makers. Provide all relevant documentation with your appeal request.

For required preservice determinations, Cigna’s review will be completed within 30 calendar days of the receipt of your appeal request. For postservice claims, Cigna’s review will be completed within 30 calendar days. 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.

Medical Necessity Appeals

Your appeal of Cigna's Adverse Determination, decision to deny, reduce or terminate a medical service based on a determination that it is not Medically Necessary or is experimental or investigational, will be considered by a Physician, or upon your request, by a reviewer, in the same or similar specialty as the care under consideration, who was not involved in the initial decision as determined by Cigna's Physician Reviewer.

For required preservice determinations, Cigna's review will be completed within 30 calendar days of the receipt of your appeal request. For postservice claims, Cigna’s review will be completed within 30 calendar days. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with your 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 decision to uphold or reverse the decision of the Physician Reviewer within five working days after the decision is made, and within the review time frames above. Notification of the appeal review decision will be provided to you and any designated representative and provider(s) acting on your behalf.

Expedited Internal Appeals

An expedited appeal will be provided when you are hospitalized or as requested when the treating provider is of the opinion that review under a standard time frame could, in the absence of immediate medical attention, result in any of the effects listed in the following paragraph.

You may request that the appeal process be expedited for an appeal of a Medical Necessity Adverse Determination or an appeal of a Coverage Denial if: the time frames under this process would seriously jeopardize your life or health, or with respect to a pregnant woman, the life or health of the unborn child; or the ability to regain maximum function; or result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part; 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 internal appeal would be detrimental to your medical condition.

When an appeal is expedited, we will respond orally with a decision within 72 hours of receipt of the appeal request, followed up in writing within three working days.

Reconsideration of an Internal Review Medical Necessity or Clinical Appropriateness Appeal Decision

You may present new clinical information regarding an adverse internal review appeal determination decision prior to the initiation of the external review process conducted by an Independent Review Entity in the process described in the following paragraph entitled, "External Review by an Independent Review Entity." If you do, Cigna will provide written notice of a reconsideration decision within five working days of receiving additional information related to the request for reconsideration. If a reconsideration is requested, the four months time frame for requesting an external review by an Independent Review Entity shall not begin until Cigna provides the reconsideration decision. If we do not provide a written reconsideration decision within the allowable time frame, then you may request an external review by an Independent Review Entity. Notification of the reconsideration of the appeal review decision will be provided to you and any designated representative or provider(s) acting on your behalf.

External Review by an Independent Review Entity

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 appeal decision or reconsideration decision regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Entity (IRE).

Your appeal of Cigna's adverse determination, decision to deny, reduce or terminate a medical service based on a determination that it is not Medically Necessary or is experimental or investigational, will be considered by a Physician or upon your request, by a reviewer, in the same or similar specialty as the care under consideration, who was not involved in the initial decision as determined by Cigna's Physician Reviewer. The Independent Review Entities that Kentucky Department of Insurance assigns in rotation to requests for external independent review are: certified by the Kentucky Department of Insurance, and 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 of any other benefits under the plan.

An IRE will provide an expedited review of an external appeal when requested, and any of the following apply: the treating Physician believes that independent review under a standard time frame would seriously jeopardize your life or health, or with respect to a pregnant woman, the life or health of the unborn child; or the ability to regain maximum function; or result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part; or 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 will pay the cost of the review of an Independent Review Entity, however, there is a $25 filing fee for you to initiate this independent review process, and you will be billed for this directly by the IRE. The IRE will waive the fee if financial hardship can be demonstrated and will refund the fee

if their review results in a decision favorable for you. Cigna will abide by the decision of the IRE, and will provide notice to the Kentucky Department of Insurance of its implementation of the decision within 30 days of the IRE's decision in your favor. Cigna will provide coverage of the treatment, service, drug or device as required by the binding decision of the IRE, if you are currently enrolled for coverage by Cigna or you have disenrolled. If you have disenrolled, Cigna will only provide the treatment, service, drug, or device for a period of 30 days.

Call the toll-free number on your Benefit Identification card or contact the appeals representative indicated on your appeal decision notification letter for information about how to request an external review appeal by an IRE.

In order to request a referral to an IRE the following conditions apply: you must submit your request in writing to Cigna, within four months of the date of this letter (except that requests for expedited appeals may be requested verbally, followed up by an abbreviated written request). However, when a reconsideration of this decision is requested due to the submission of new clinical information, the four months time frame limit for requesting an external review by an IRE will not begin until Cigna has provided a reconsideration decision; you provide a signed copy of the medical release form which provides permission for the IRE to obtain all of the necessary medical records in order to complete its review; you were insured at time of service, or when you or your provider requested the service you have exhausted the Cigna internal review process and received an adverse decision regarding your request involving a Medical Necessity issue; or Cigna has not completed its review of your internal review appeal within the required 30 days; or the Kentucky Department of Insurance has provided notice that Cigna's Coverage Denial determination is not valid because the requested service or coverage is available under the plan. If you believe that you are entitled to an IRE review and Cigna has denied your request for an IRE review, you may file a complaint with the Kentucky Department of Insurance, which shall issue a decision within five days of the receipt of your complaint. If the Department agrees that you are entitled to an IRE review, it shall require Cigna to provide one, as noted above.

If both Cigna and you agree to waive the internal appeal requirement, you may also request that your eligible issue be referred directly to an IRE without initiating or exhausting the internal appeals process.

Cigna will not provide an external review by an IRE if the request for review of the adverse determination has previously gone through the external review process and the IRE found in favor of Cigna and no new clinical information has been submitted since the IRE found in favor of Cigna.

Cigna will forward your request and the file to the IRE, after the Department of Insurance assigns an IRE to your review request.

If you believe that you are entitled to an IRE review and Cigna has denied your request for an IRE review, you may file a complaint with the Kentucky Department of Insurance, which shall issue a decision within five days of the receipt of your complaint. If the Department agrees that you are entitled to an IRE review, it shall require Cigna to provide one, as noted above.

The IRE will render an opinion within 21 calendar days, unless you and Cigna agree to an extension of up to 14 calendar days more. When requested, and when your provider believes that review under a standard time frame would be detrimental to your medical condition, Cigna shall forward your request for an IRE review to the IRE within 24 hours of receiving it, and the IRE will make a decision within 24 hours of receipt of all information required from Cigna. If you agree to a 24-hour extension for the expedited review, then the IRE will provide an expedited decision of the review request within 48 hours of receipt of all information required from Cigna, but no later than 72 hours of receiving your request for an IRE from Cigna.

The external review process shall be confidential.

External Review of a Coverage Denial by the Kentucky Department of Insurance

You have the right to ask the Kentucky Department of Insurance to review a Coverage Denial determination that has been made following an internal appeal. A Coverage Denial means a determination that a service, treatment, prescription drug or device is specifically limited or excluded under the Plan. You, or an authorized person or provider on your behalf, may submit a written request for review of a Coverage Denial to the Kentucky Department of Insurance at the following address:

Kentucky Department of Insurance
Attn: Coverage Denial Coordinator
P.O. Box 517
Frankfort, KY 40602-0517

Include a copy of the initial Cigna denial notice and the appeal notice with your written request for review of a Coverage Denial. Upon Cigna's receipt of the Kentucky Department of Insurance's (DOI's) determination decision of your Coverage

Denial review request, Cigna will: provide the disputed coverage if the DOI has concluded that the treatment, service, drug or device is not specifically limited or excluded by the plan or offer you the opportunity to seek an external review by an Independent Review Entity; or not provide the disputed coverage if the DOI has concluded that the treatment, service, drug or device is not specifically limited or excluded by the Plan. When Cigna provides the coverage because the DOI has determined the treatment, service, drug or device is not specifically limited or excluded by the plan, it will provide coverage if you are currently enrolled for coverage by Cigna or you have disenrolled. If you have disenrolled, Cigna will only provide coverage for the treatment, service, drug, or device for a period of 30 days.

Assistance from the State Of Kentucky

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

Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517
1-800-595-6053
Hearing Impaired: 1-800-462-2081

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; 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; date of the review decision; name and title of the person making the review decision and for Medical Necessity determinations, the name, state of licensure, medical license number and the title of the person making the determination and, as applicable to managed care plans, the signature of a Kentucky-licensed Medical Director; a description of alternative benefits, supplies or services covered by the plan; instructions for requesting an external review by either an IRE or the Kentucky Department of Insurance, as applicable, including applicable time frames and instructions to complete any required forms and whether the request for review of the appeal decision must be in writing; for Medical Necessity appeal determinations, a release of medical records form for provision to the IRE; the name and phone number of a contact person who can provide information about a Coverage Denial determination or about external review by an IRE, as applicable; and for Coverage Denial appeal notices, instructions to include a copy of the initial Coverage Denial notice and the Coverage Denial notice with the written request to the Department of Insurance to conduct a review of a Coverage Denial appeal determination; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process.

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 Internal Review Appeal process.

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.

Definitions

Prescription Drug Product

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

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

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

CERTIFICATE RIDER – 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.

HC-ETLARDR

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 V1 ET

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 or Doula providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.

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 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 or Specialist

SCHEDLA-laet2c

Covered Expenses

- 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.

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.

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).

Limitations

Step Therapy

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.

HC-PHR516 01-21

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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:

  - 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” section(s) 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” section(s) 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 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 received medical literature.

HC-PHR691 01-23
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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.

HC-PHR138 10-16
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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.

HC-EXC567 01-23
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Termination of Insurance

Continuation

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.

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 years old, but less than 30, unmarried, enrolled in school as a full-time student and primarily supported by you.
  - 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 30 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 or student will continue until the last day of the calendar year 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.

HC-DFS1575 ET

Doula

An individual who has been trained to provide physical, emotional, and educational support, but not medical or midwifery care, to pregnant and birthing women and their families before, during, and after childbirth.

HC-DFS1886 01-23
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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

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.

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 for elective and non-elective abortion and abortion related care.
- charges for donated breast milk for a covered Dependent child, when prescribed by a licensed medical practitioner stating that: the child is medically or physically unable to receive maternal breast milk or participate in breast feeding or the child's mother is medically or physically unable to produce maternal breast milk in quantities sufficient for the infant; and:
  - the child was born at a birth weight of less than 1,500 grams;
  - has a gastrointestinal anomaly or metabolic or digestive disorder or is recovering from intestinal surgery and the infant's digestive needs require additional support;
  - is not appropriately gaining weight or growing;
  - has formula intolerance and is experiencing weight loss or difficulty feeding;
  - has low blood sugar;
  - has congenital heart disease;
  - has received or will receive an organ transplant; or
  - has another serious medical condition for which donor breast milk is Medically Necessary.
- 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 laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability.

Fertility Services

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

Services include, but are not limited to: injectable fertility drugs which are administered or provided by a Physician; cryopreservation, storage, and thawing of sperm, eggs and embryos; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable

likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; intrauterine insemination/artificial insemination; diagnostic evaluations; assisted reproductive techniques (ART) including in vitro fertilization (IVF); and the services of an embryologist.

Oral fertility drugs are covered under the Pharmacy benefit.

Infertility is defined as:

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

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

The following are specifically excluded infertility services:

- reversal of male and female voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- non-medical costs related to donor charges and services;
- pre-implantation genetic material and pre-implantation genetic screening (PGS/PGT-A) of parents/donors beyond what is covered by the medical plan.

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.

HC-CNV 04-10
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The Schedule

The pharmacy Schedule is amended to indicate the following:

Abortion Medication

Your charge for Prescription Drugs related to abortion services will be covered at no cost share.

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

SCHEDPHARM90-meet

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.

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 either:

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

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

- 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.

Definitions

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

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 "**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

SCHEDMD-ET3

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

CERTIFICATE RIDER – Michigan Residents

Rider Eligibility: Each Employee who is located in Michigan

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

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

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

HC-ETMIRDR

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.

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Prescription Drug Benefits

Limitations

Prescription Eye Drops Refills

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

(a) For a 30-day supply, once 23 days have passed after either of the following:
- The original date the prescription was distributed to you.
- The date the most recent refill was distributed to you.

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

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

HC-PHR375 01-20
ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

HC-EXC638 01-26
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Expenses For Which A Third Party May Be Responsible

- 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. The coverage under this plan is secondary to any automobile no-fault insurance or similar coverage, except the coverage under this plan is primary to a Michigan automobile no-fault insurance policy issued to a Michigan resident if that insurance policy coordinates or states that it is secondary to group health insurance.

HC-SUB124 01-20
ET

Prescription Drug Benefits

Limitations

Supply Limits

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

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

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

HC-PHR583 01-23
ET

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

CERTIFICATE RIDER – Missouri Residents

Rider Eligibility: Each Employee who is located in Missouri

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

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

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

HC-ETMORDR

Important Notices

Missouri First Steps Program

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

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

Missouri Utilization Review Decisions and Procedures

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

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

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

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

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

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

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

Cigna shall have written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. These procedures shall be made available to providers on Cigna's website or provider portal. In cases where the provider or a covered person will not release necessary information, Cigna may deny certification of an admission, procedure or service.

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

The Schedule

Out-of-Network Charges for Certain Services

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

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

Out-of-Network Emergency Services Charges

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

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

The Schedule

Note:

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

Covered Expenses

- Coverage for low-dose mammography screening, including digital mammography and breast tomosynthesis, for any nonsymptomatic woman covered under such policy or contract which meets the minimum requirements of this section. Such coverage shall include at least the following: a baseline mammogram for women age 35 to 39, inclusive; a mammogram every year for women age 40 and over; a mammogram every year for any woman deemed by a treating Physician to have an above-average risk for breast cancer in accordance with the American College of Radiology guidelines for breast cancer screening; any additional or supplemental imaging, such as breast magnetic resonance imaging or ultrasound, deemed Medically Necessary by a treating Physician for proper breast cancer screening or evaluation in accordance with applicable American College of Radiology guidelines; and ultrasound or magnetic resonance imaging services, if determined by a treating Physician to be Medically Necessary for the screening or evaluation of breast cancer for any woman deemed by the treating Physician to have an above-average risk for breast cancer in accordance with American College of Radiology guidelines for breast cancer screening.
- Low Dose Mammography Screening means the x-ray examination of the breast using equipment specifically designed and dedicated for mammography, including the x-ray tube, filter, compression device, detector, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast, and any fee charged by a radiologist or other Physician for reading, interpreting or diagnosing based on such x-ray. Breast Tomosynthesis means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.
- charges made by a Hospital or an ambulatory surgical facility for anesthesia for inpatient Hospital dental procedures for: a child under the age of five; a person with a severe disability; or a person with a behavioral or medical condition that requires hospitalization or general anesthesia when dental care is provided in a participating hospital, surgical center or office. Cigna may require prior authorization for hospitalization for dental procedures.
- charges for immunizations (including the associated office visit) for children from birth to five years of age as provided by department of health and senior services regulations. This includes the office visit in connection with immunizations. There will be no Deductible and no Copay.
- charges for or in connection with the diagnosis, treatment and appropriate management of osteoporosis for persons with a condition or medical history for which bone mass measurement is Medically Necessary, provided such services are received by a Physician licensed to practice medicine and surgery in Missouri.
- charges for a colorectal examination and laboratory tests for cancer in accordance with current American Cancer Society guidelines for any nonsymptomatic person covered under the Plan.
- charges for a pelvic examination and Pap smear in accordance with current American Cancer Society guidelines for any nonsymptomatic woman covered under the Plan.
- charges for prostate cancer examinations and laboratory tests for any insured nonsymptomatic male, in accordance with current American Cancer Society guidelines. Men age 50 and older should discuss getting an annual PSA blood test and a digital rectal exam with their Physician. Men who are at risk, which includes African American or men who have a family history of prostate cancer, should consider being tested at a younger age.
- charges made by a Hospital or other facility that provides obstetrical care for inpatient Hospital services will include

Covered Expenses for a mother and her newborn child for 48 hours following a vaginal delivery or for 96 hours following a cesarean delivery. A longer stay will be covered if deemed Medically Necessary. The mother may request an earlier discharge if, after consulting with her Physician, it is determined that less time is needed for recovery. If discharged early, at least 2 post discharge visits will be covered, one of which will be a home visit by either a registered Nurse with experience in maternal and child health nursing or a Physician. These visits will include, but are not limited to, a physical assessment of the mother and the newborn; parent education; assistance and training in breast and bottle feeding; education and services for complete childhood immunizations; Medically Necessary clinical tests; and the submission of a metabolic specimen to the state laboratory.

Autism Spectrum Disorder and Applied Behavior Analysis

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

Other Developmental or Physical Disabilities

Coverage is provided for the diagnosis and treatment of a developmental or physical disability, and care prescribed or ordered for a Member diagnosed with a developmental or physical disability by a licensed Physician or licensed Psychologist, including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician's or licensed Psychologist's license, including but not limited to: psychiatric care; psychological care; habilitative or rehabilitative care, excluding behavior analysis therapy; therapeutic care; and pharmacy care. Coverage cannot be denied on the basis that it is educational or habilitative in nature. Benefits for the diagnosis and treatment of developmental or physical disabilities are not subject to any age, dollar or visit limits.

The terms used above are defined as follows:

- **Autism spectrum disorders** means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- **Developmental or physical disability** means a severe chronic disability that:
  - is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness or autism spectrum disorder which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services; manifests before the individual reaches age nineteen; is likely to continue indefinitely; and results in substantial functional limitations in three or more of the following areas of major life activities:
  - self-care;
  - understanding and use of language;
  - learning;
  - mobility;
  - self-direction; or
  - capacity for independent living.
- **Diagnosis** means Medically Necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder or a developmental or physical disability.

- **Treatment** means care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed Physician or licensed Psychologist, or for an individual diagnosed with a developmental or physical disability by a licensed Physician or licensed Psychologist, including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician's or licensed Psychologist's license, including, but not limited to: psychiatric care; psychological care; habilitative or rehabilitative care, including applied behavior analysis therapy; for those diagnosed with autism spectrum disorder; therapeutic care; and pharmacy care.
- **Autism service provider** means any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst.
- **Applied behavior analysis** means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.
- **Habilitative or rehabilitative care** is professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual.
- **Line therapist** means an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.
- **Pharmacy care** means medications used to address symptoms of an autism spectrum disorder prescribed by a licensed Physician, and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications, only to the extent that such medications are included in the insured's health benefit plan.
- **Psychiatric care** means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- **Psychological care** means direct or consultative services provided by a Psychologist licensed in the state in which the Psychologist practices.
- **Therapeutic care** means services provided by licensed speech therapists, occupational therapists, or physical therapists.

Diagnosis and Treatment of Eating Disorders

Coverage is provided for the diagnosis and treatment of eating disorders when Medically Necessary, that is provided by a licensed treating Physician, psychiatrist, Psychologist, professional counselor, clinical social worker, or licensed marital and family therapist pursuant to the powers granted under such licensed Physician's, psychiatrist's, Psychologist's, professional counselor's, clinical social worker's or licensed marital and family therapist license and acting within their applicable scope of coverage in accordance with a treatment plan. Medical Necessity determinations and care management shall consider the overall medical and mental health needs and not be based solely on weight, and shall take into consideration the most recent Practice Guidelines for the Treatment of Patients with Eating Disorders adopted by the American Psychiatric Association in addition to current standards based upon the medical literature generally recognized as authoritative in the medical community. The treatment plan, upon request by Cigna, shall include all elements necessary for Cigna to pay claims. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals.

The terms used above are defined as follows:

- **Eating disorder**, Pica, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder, Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Other Specified Feeding or Eating Disorder, and any other eating disorder contained in the most recent version of the DSM of Mental Disorders published by the American Psychiatric Association where diagnosed by a licensed Physician, psychiatrist, Psychologist, clinical social worker, licensed marital and family therapist, or professional counselor duly licensed in the state where he or she practices and acting within their applicable scope of practice in the state where he or she practices;
- **Pharmacy care,** medications prescribed by a licensed Physician for an eating disorder and includes any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications, but only to the extent that such medications are included in the insured's health benefit plan;

- **Treatment of eating disorders**, therapy provided by a licensed treating Physician, psychiatrist, Psychologist, professional counselor, clinical social worker, or licensed marital and family therapist pursuant to the powers granted under such licensed Physician's, psychiatrist's, Psychologist's, professional counselor's, clinical social worker's, or licensed marital and family therapist's license in the state where he or she practices for an individual diagnosed with an eating disorder.
- charges for virtual care will be covered on the same basis as covered services provided through a face to face diagnosis, consultation, treatment or contact with a Participating Provider. Coverage does not include virtual care site origination fees or costs for the provision of virtual care services. Utilization may be utilized to determine the appropriateness of virtual care as a means of delivering a health care service on the same basis as when the same service is delivered in person.

Outpatient Therapy Services

Chiropractic Care Services

- charges for diagnostic and treatment services by chiropractic Physicians. The practice of chiropractic is defined as the science and art of examination, diagnosis, adjustment, manipulation and treatment both in inpatient and outpatient settings and may include meridian therapy/acupressure/acupuncture with certification as required by the board. For these services you have direct access to qualified chiropractic Physicians.

A Copayment that exceeds fifty percent of the total cost of providing any single chiropractic service to a covered person will never be imposed.

Coverage is provided when Medically Necessary in the most medically appropriate setting to:

- restore function (called “rehabilitative”):
  - to restore function that has been impaired or lost.
  - to reduce pain as a result of Sickness, Injury, or loss of a body part.
- improve, adapt or attain function (sometimes called “habilitative”):
  - to improve, adapt or attain function that has been impaired or was never achieved as a result of congenital abnormality (birth defect).
  - to improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions. Includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.

Coverage is provided as part of a program of treatment when the therapy is provided by, or under the direct supervision of, a licensed health care professional acting within the scope of the license and is Medically Necessary and medically appropriate for the diagnosed condition.

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

Therapy services that are not covered include:

- sensory integration therapy.
- treatment of dyslexia.
- maintenance or preventive treatment provided to prevent recurrence or to maintain the patient’s current status.
- vitamin therapy.

Coverage is administered according to the following:

- multiple therapy services provided on the same day constitute one day of service for each therapy type.

Chiropractic Care Services

Charges made for the science and art of examination, diagnosis, adjustment, manipulation and treatment both in inpatient and outpatient settings, by those methods commonly taught in any chiropractic college or chiropractic program in a university which has been accredited by the Council on Chiropractic Education, its successor entity or approved by the board. It shall not include the use of operative surgery, obstetrics, osteopathy, podiatry, nor the administration or prescribing of any drug or medicine nor the practice of medicine.

The practice of chiropractic may include meridian therapy/acupressure/acupuncture with certification as required by the board.

A copayment that exceeds fifty percent of the total cost of providing any single chiropractic service to a covered person will never be imposed.

Prescription Drug Benefits

Limitations

Supply Limits

Coverage for the refilling of an eye drop prescription prior to the last day of the prescribed dosage period without regard to a coverage restriction for early refill of prescription renewals as long as the prescribing health care provider authorizes such early refill, and the health carrier or the health benefit plan is notified will be provided.

Synchronization of Prescription Drug Orders or Refills:

Prescription drug coverage shall provide for synchronization of prescription drug refills.

Cigna shall:

- not charge an amount in excess of the otherwise applicable co-payment amount under the plan for dispensing a prescription drug in a quantity that is less than the prescribed amount if the Pharmacy dispenses the prescription drug in accordance with the medication synchronization services offered under the Plan and a Participating Provider dispenses the prescription drug; and
- provide a full dispensing fee to the pharmacy that dispenses the prescription drug to the covered person.

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for a continuous course of dental treatment for an accidental Injury to teeth are covered. Additionally, charges made by a Hospital or an ambulatory surgical facility for anesthesia for inpatient Hospital dental procedures for: a child under the age of five; a person with a severe disability; or a person with a behavioral or medical condition that requires hospitalization or general anesthesia when dental care is provided in a participating Hospital, surgical center or office are covered.
- non-medical counseling and/or ancillary services, including but not limited to Custodial Services, educational services, vocational counseling training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.

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 **Elective Abortion** means an abortion for any reason other than a spontaneous abortion or to prevent the death 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 of the female upon whom the abortion is performed).

The Exclusions and Expenses Not Covered provision in your certificate is amended to delete the following exclusion:

- elective abortions.

Alicia M. Morrow, ESQ, Corporate Secretary

Bryan Holgerson, President

Wilbur E. Parsell, Registrar

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.

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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.

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

CERTIFICATE RIDER – New Hampshire Residents

Rider Eligibility: Each Employee who is located in New Hampshire

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

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

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

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Mental Health and Substance Use Disorder Services

The plan covers charges for mental health and substance use disorder services rendered by psychiatrists, licensed psychologists, licensed pastoral psychotherapists, psychiatric/mental health advanced registered nurse practitioners, licensed clinical mental health counselors,

licensed alcohol and drug counselors, licensed marriage and family therapists, licensed clinical social workers, and licensed psychiatrist-supervised physician assistants.

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

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

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

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

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

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

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

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

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

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

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

Mental Health Intensive Outpatient Services are active, time-limited, ambulatory mental health treatment programs that offer structured and coordinated, multi-disciplinary

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

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

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

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

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

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

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

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

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

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

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

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

CERTIFICATE RIDER – New Jersey Residents

Rider Eligibility: Each Employee who is located in New Jersey

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

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

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

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

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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.

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Definitions

Dependent

Dependents include:

- your lawful spouse or civil union partner; or
- any child of yours who is:
  - less than 26 years old.
  - 26 years old, but less than 30, 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.

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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.

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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-IMP442 01-24
ET

Covered Expenses

- charges for general anesthesia and associated Hospital or ambulatory surgical facility charges in connection with dental procedures for:
  - a child who is eight years or younger;
  - individuals with serious mental or physical conditions; and
  - individuals with significant behavioral problems.

  The treating provider must certify that hospitalization or general anesthesia is required in order to safely and effectively perform the procedures.
- charges for the treatment of congenital defects or abnormalities, including necessary treatment and care of cleft lip or cleft palate.
- charges made for surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) excluding orthodontic treatment.

HC-COV1611 01-24
ET4

Clinical Trials

Clinical Trial Costs

If a claim contains charges related to services required and those charges cannot be separated from costs related to services for which coverage is not required, the health benefit plan may deny the claim.

Clinical trial costs not required to be covered by a health benefit plan include:

- non-health care services, those services provided solely to satisfy data collections and analysis needs; and
- investigation drugs and devices, and services not provided for the direct clinical management of the patient.

HC-COV1119 03-21
ET

Exclusions

- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.

HC-PHR799 01-24
ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

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

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem. This does not include coverage for congenital defects or anomalies.

HC-EXC622 01-24
ET

Definitions

Dependent

The term child means a child born to you, a foster child, a foster child placed in the foster home, a child placed for adoption. A child includes an adopted child or foster child including that child from the first day of placement in your home regardless of whether the adoption has become final.

HC-DFS1723 01-22
ET

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

CERTIFICATE RIDER – Ohio Residents

Rider Eligibility: Each Employee who is located in Ohio

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

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

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

HC-ETOHRDR

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.

Virtual Care - Medical

Dedicated Virtual Providers/Telemedicine

Includes charges for the delivery of real-time medical and health-related services and consultations by dedicated virtual providers as medically appropriate through synchronous or asynchronous information and communication technology.

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

Virtual Physician Services/Telemedicine

Includes charges for the delivery of real-time medical and health-related services and consultations as medically appropriate through synchronous or asynchronous information and communication technology that are similar to office visit services provided in a face-to-face setting.

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

- charges made for Medically Necessary Synchronous Teledentistry.

HC-COV1599 01-25

ET3

Prescription Drug Benefits

Limitations

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card. Your Provider may request a Step Therapy exemption. An exemption request will be granted or denied within 48 hours for a request related to urgent care services and 10 calendar days for all other requests. See your Appeals section of this certificate for your Appeal rights.

These requirements do not apply to prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions.

Supply Limits

Prescription drug coverage shall provide for medication synchronization for an insured if all of the following conditions are met: (1) the insured elects to participate in medication synchronization; (2) The insured, prescriber, and Pharmacist at a Network Pharmacy agree that medication synchronization is in the best interest of the insured; (3) The prescription drug meets the requirements to be eligible for inclusion in medication synchronization.

To be eligible a drug must: (1) Be covered under the plan; (2) Be prescribed for the treatment and management of a chronic disease or condition and be subject to refills; (3) Satisfy all relevant prior authorization criteria; (4) Not have any quantity limits, dose optimization criteria, or other requirements that would be violated if synchronized; (5) Not have any special handling or sourcing needs, as determined by the plan that require a single Designated Pharmacy to fill or refill the prescription; (6) Be formulated so that the quantity or amount dispensed can be effectively divided in order to achieve synchronization; (7) Not be a schedule II controlled substance, opiate, or benzodiazepine. A policy or plan shall authorize coverage of a prescription drug subject to medication synchronization when the drug is dispensed in a quantity or amount that is less than a thirty one (31) day supply. Medication synchronization applies only once for each prescription drug subject to medication synchronization for the same insured unless; a) the prescriber changes the dosage or frequency of administration of a prescription drug subject to medication synchronization or; b) the prescriber prescribes a different drug. Shall permit and apply a prorated daily cost-sharing rate for a supply of a prescription drug subject to medication synchronization that is dispensed at a Network Pharmacy. Requirement does not waive any cost sharing in its entirety.

"Medication synchronization" means a pharmacy service that synchronizes the filling or refilling of prescriptions in a manner that allows the dispensed drugs to be obtained on the same date each month.

"Cost-sharing" means the cost to an insured according to any coverage limit, Copayment, Coinsurance, Deductible, or other Out-of-Pocket expense requirements imposed by the policy or plan.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Specialty Prescription Drug Products

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

HC-PHR569 01-23
ET

Prescription Drug Benefits

Limitations

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card. Your Provider may request a Step Therapy exemption. An exemption request will be granted or denied within 48 hours for a request related to urgent care services and 10 calendar days for all other requests. See your Appeals section of this certificate for your Appeal rights.

These requirements do not apply to prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions.

Supply Limits

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

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T

Committee’s clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

Prescription drug coverage shall provide for medication synchronization for an insured if all of the following conditions are met: (1) the insured elects to participate in medication synchronization; (2) The insured, prescriber, and pharmacist at a Network Pharmacy agree that medication synchronization is in the best interest of the insured; (3) The prescription drug meets the requirements to be eligible for inclusion in medication synchronization.

To be eligible a drug must: (1) Be covered under the plan; (2) Be prescribed for the treatment and management of a chronic disease or condition and be subject to refills; (3) Satisfy all relevant prior authorization criteria; (4) Not have any quantity limits, dose optimization criteria, or other requirements that would be violated if synchronized; (5) Not have an special handling or sourcing needs, as determined by the plan that require a single designated Pharmacy to fill or refill the prescription; (6) Be formulated so that the quantity or amount dispensed can be effectively divided in order to achieve synchronization; (7) Not be a schedule II controlled substance, opiate, or benzodiazepine.

A policy or plan shall authorize coverage of a prescription drug subject to medication synchronization when the drug is dispensed in a quantity or amount that is less than a thirty one (31) day supply. Medication synchronization applies only once for each prescription drug subject to medication synchronization for the same insured unless; a) the prescriber changes the dosage or frequency of administration of a prescription drug subject to medication synchronization or; b) the prescriber prescribes a different drug.

Shall permit and apply a prorated daily cost-sharing rate for a supply of a prescription drug subject to medication synchronization that is dispensed at a Network Pharmacy. Requirement does not waive any cost-sharing in its entirety.

"Medication synchronization" means a pharmacy service that synchronizes the filling or refilling of prescriptions in a manner that allows the dispensed drugs to be obtained on the same date each month.

"Cost-sharing" means the cost to an insured according to any coverage limit, Copayment, Coinsurance, Deductible, or other Out-of-Pocket expense requirements imposed by the policy or plan.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Specialty Prescription Drug Products

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

HC-PHR576 01-23
ET

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.

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.

"**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.

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 appeal review, 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.

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: availability, upon request, of the diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse benefit determination including, if applicable, the denial code and its meaning and 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); 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. However, no action may be brought at all unless brought within three years after a claim is submitted for In-Network services.

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.

“**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.

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 appeal review, 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.

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 72 hours 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: availability, upon request, of the diagnosis and treatment codes, and their meaning; the specific reason or reasons for the adverse benefit 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); 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. 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-APL499 01-25
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, a foster child, or a child for whom you are the legal guardian.

HC-DFS1690 01-23
ET

Definitions

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 – 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

Covered Expenses

- charges for an annual breast cancer screening. 3-Dimensional screenings are not subject to any member cost-share.
- charges for an annual supplemental breast cancer screening when Medically Necessary and clinically appropriate using either standard or abbreviated magnetic resonance imaging (MRI), or ultrasound if MRI is not possible, not subject to member cost-share, for a woman who is at an increased risk of breast cancer.
- 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.

HC-COV1511 01-24
ET

Definitions

Dependent

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

HC-DFS1675 01-22
ET

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

Covered Expenses

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

HC-COV1554 01-24
ET1

Prescription Drug Benefits

Covered Expenses

Contraceptives

Covered Expenses includes charges for Prescription Drug Products used for contraception.

HC-PHR760 01-24
ET

Definitions

Dependent

A child includes a legally adopted child, including that child from the first day of placement in your home regardless of whether the adoption has become final, or an adopted child of whom you have custody according to the decree of the court provided you have paid premiums. Adoption proceedings must be instituted by you, and completed within 31 days after the child's birth date, and a decree of adoption must be entered within one year from the start of proceedings, unless extended by court order due to the child's special needs.

HC-DFS273 04-10
V1-ET

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

CERTIFICATE RIDER – Tennessee Residents

Rider Eligibility: Each Employee who is located in Tennessee

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

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

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

HC-ETTNRDR

The Schedule

If you are enrolled in a medical plan other than a Comprehensive medical plan, The Schedule of your medical certificate is amended as follows:

The In-Network Outpatient Therapy Services provision in The Schedule of your medical certificate is updated to indicate it is subject to the same cost-share as any other Primary Care Physician’s office visit.

If the Outpatient Therapy Services provision is subject to a maximum, the text "for all therapies combined" is hereby removed.

If the Outpatient Therapy Services provision in The Schedule of your medical certificate includes Chiropractic Care/Self-Referral Chiro, it is hereby covered as a separate benefit and not subject to any separate Chiropractic Care/Self-Referral Chiro maximum. In-Network Chiropractic Care/Self-Referral Chiro will be paid the same as any other Primary Care Physician's office visit.

If you are enrolled in a Comprehensive medical plan, The Schedule of your medical certificate is amended as follows:

The Outpatient Therapy Services provision is subject to the same cost-share as any other Primary Care Physician's office visit.

If the Outpatient Therapy Services provision is subject to a maximum, the text "for all therapies combined" is hereby removed.

If the Outpatient Therapy Services provision in The Schedule of your medical certificate includes Chiropractic Care, it is hereby covered as a separate benefit, not subject to any separate Chiropractic Care maximum and subject to the same cost-share as any other Primary Care Physician's office visit.

SCHEDTN-tnetc

Covered Expenses

- charges for treatment of conditions or disorders of hearing, speech, voice or language if treatment is received from a licensed audiologist or speech pathologist.

HC-COV1668 01-26

ET1

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

Notice of Coverage for Acquired Brain Injury

Your health benefit plan coverage for an acquired brain injury includes the following services:

- cognitive rehabilitation therapy;
- cognitive communication therapy;
- neurocognitive therapy and rehabilitation;
- neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment;
- neurofeedback therapy and remediation;
- post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and
- reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute care treatment or services may be obtained in any facility where such services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

The following words and terms shall have the following meanings:

Acquired brain injury -- A neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Cognitive communication therapy -- Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive rehabilitation therapy -- Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Community reintegration services -- Services that facilitate the continuum of care as an affected individual transitions into the community.

Enrollee -- A person covered by a health benefit plan.

Health benefit plan -- As described in the Insurance Code §1352.001 and §1352.002.

Issuer -- Those entities identified in the Insurance Code §1352.001.

Neurobehavioral testing -- An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

Neurobehavioral treatment -- Interventions that focus on behavior and the variables that control behavior.

Neurocognitive rehabilitation -- Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive therapy -- Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback therapy -- Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological testing -- An evaluation of the functions of the nervous system.

Neurophysiological treatment -- Interventions that focus on the functions of the nervous system.

Neuropsychological testing -- The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological treatment -- Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Other similar coverage -- The medical/surgical benefits provided under a health benefit plan. This term recognizes a distinction between medical/surgical benefits, which encompass benefits for physical illnesses or injuries, as opposed to benefits for mental/behavioral health under a health benefit plan.

Outpatient day treatment services -- Structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

Post-acute care treatment services -- Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-acute transition services -- Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Psychophysiological testing -- An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological treatment -- Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Remediation -- The process(es) of restoring or improving a specific function.

Services -- The work of testing, treatment, and providing therapies to an individual with an acquired brain injury.

Therapy -- The scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

Examinations for Detection of Cervical Cancer

Benefits are provided for each covered female age 18 and over for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Benefits include at a minimum a conventional Pap smear screening; or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224 or write us at the address on the back of your ID card.

Coverage and/or Benefits For Reconstructive Surgery After Mastectomy – Enrollment

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

- all stages of the reconstruction of the breast on which mastectomy has been performed;
- surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
- prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending Physician.

Prohibitions:

We may not:

- offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above;
- condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above;
- reduce or limit the amount paid to the Physician or provider, nor otherwise penalize, or provide a financial incentive to induce the Physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224 or write us at the address on the back of your ID card.

Coverage and/or Benefits For Reconstructive Surgery After Mastectomy – Annual

Your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224 or write us at the address on the back of your ID card.

Coverage for Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

- 48 hours following a mastectomy, and
- 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending Physician determine that a shorter period of inpatient care is appropriate.

Prohibitions:

We may not:

- deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours;
- provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours;
- reduce or limit the amount paid to the attending Physician, or otherwise penalize the Physician, because the Physician required a covered person to receive the minimum inpatient hours; or
- provide financial or other incentives to the attending Physician to encourage the Physician to provide care that is less than the minimum hours.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224 or write us at the address on the back of your ID card.

Coverage for Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

- a physical examination for the detection of prostate cancer; and
- a prostate-specific antigen test for each covered male who is:
  - at least 50 years of age; or
  - at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224 or write us at the address on the back of your ID card.

Coverage for Inpatient Stay Following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery, and
- 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a Hospital or Other Health Care Facility or (b) remain in a Hospital or Other Health Care Facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a Physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions:

We may not:

- modify the terms of this coverage based on any covered person requesting less than the minimum coverage required;
- offer the mother financial incentives or other compensation for waiver of the minimum number of hours required;
- refuse to accept a Physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the Physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians;
- reduce payments or reimbursements below the usual and customary rate; or
- penalize a Physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224 or write us at the address on the back of your ID card.

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 45 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include:

- all colorectal cancer examinations, preventative services, and laboratory tests assigned a grade A or B by the U.S. Preventive Services Task Force for average-risk individuals, including services that may be assigned a grade of A or B in the future; and
- an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

Cost-sharing requirements may be imposed if the service or benefits is obtained from an Out -of-Network provider. If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224, or write us at the address on the back of your ID card.

HC-IMP400 01-25

ET1

The Schedule

The following sentence is added to the “Hospital Emergency Room” section under the “Emergency and Urgent Care Services” section of **The Schedule** shown in your medical certificate:

Emergency and Urgent Care Services

Hospital Emergency Room

(including a properly licensed freestanding emergency medical care facility)

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

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

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

SCHEDTX ET

Covered Expenses

- charges made for an annual low dose mammography screening for women 35 years of age and older. Coverage will also be provided for a diagnostic imaging.
  - Diagnostic imaging means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate: a subjective or objective abnormality detected by a Physician or patient in a breast; an abnormality seen by a Physician on a screening mammogram; an abnormality previously identified by a Physician as probably benign in a breast for which follow-up imaging is recommended by a Physician; or an individual with a personal history of breast cancer or dense breast tissue.
  - Low dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, and screens with an average radiation exposure delivery of less than on rad mid-breast and with two views for each breast, digital imaging or breast tomosynthesis.
  - Breast tomosynthesis means a radiologic mammography procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which applicable breast cancer screening diagnoses may be determined.
- charges for men's family planning, counseling, testing and sterilization (e.g. vasectomies), excluding reversals.
- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage or oral contraceptives.
- charges made for reconstructive surgery of craniofacial abnormalities for a child who is younger than 18 years of age to improve the function of, or to attempt to create a normal appearance for an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease.
- charges made for an acquired brain injury including the following when they are Medically Necessary: cognitive rehabilitation therapy; cognitive communication therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment; neurofeedback therapy and remediation; post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and reasonable expenses related to periodic re-evaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.
- charges made for an annual medically recognized diagnostic examination for the early detection of cervical and ovarian cancer for each covered female age 18 and over. Such coverage shall include at a minimum: a CA 125 blood test and a conventional pap smear screening; or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus; and any other test or screening approved by the FDA for detection of ovarian cancer.
- charges for a screening test for hearing loss from birth through the date the child is 30 days old, and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.
- 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 made for all generally recognized services prescribed in relation to Autism Spectrum Disorder for Dependent children. Such coverage must include a screening at the ages of 18 and 24 months. Such coverage must be prescribed by a Physician in a treatment plan and shall include evaluation and assessment services; applied behavior analysis; behavior training and behavior management; speech therapy; occupational therapy; physical therapy; or medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder. The individual prescribing such treatment must be a health care practitioner:
  - who is licensed, certified, or registered by an appropriate agency of this state;
  - whose professional credential is recognized and accepted by an appropriate agency of the United States;
  - who is certified as a provider under the TRICARE military health system; or
  - an individual acting under the supervision of a health care practitioner described above.

  Autism Spectrum Disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder--Not Otherwise Specified. Neurobiological disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors.
- charges for inpatient care for a mother and her newborn child for 48 hours following an uncomplicated vaginal delivery, or for 96 hours following an uncomplicated cesarean delivery in a health care facility. Any decision to shorten the stay must be made by the Physician in consultation with the mother. If the mother is discharged prior to the 48 or 96 hours described above, a postdelivery home care visit will be covered. Postdelivery home care services include parent education; assistance and training in breast feeding and bottle feeding; and the performance of any necessary and appropriate clinical tests. If Medical Necessity requires the mother and/or newborn to remain confined for longer than 48 hours, the additional confinement will be covered.
- charges for administration of newborn screening tests, including for the cost of a newborn screening test kit as dictated by the Department of State Health Services.
- charges for Medically Necessary diagnostic, treatment and surgical procedures for conditions effecting temporomandibular joint and craniomandibular disorders which are a result of: an accident; trauma; a congenital defect; a developmental defect; or a pathology.
- charges made for surgical and nonsurgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- charges made for or in connection with annual diagnostic examinations for the detection of prostate cancer, regardless of Medical Necessity. Benefits include a physical exam and a prostate-specific antigen (PSA) test for a man who is at least 50 years of age or at least 40 years of age with a family history of prostate cancer, or another prostate cancer risk factor.
- charges for a minimum of 48 hours of inpatient care following a mastectomy and a minimum 24 hours following a lymph node dissection for the treatment of breast cancer. A shorter period of inpatient care may be deemed acceptable if the insured consults with the Physician and both agree it is appropriate.
- charges for immunizations for children from birth through age 5. These immunizations will include: diphtheria; Haemophilus influenzae type B; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella (chicken pox); rotavirus; and any other children's immunizations required by the State Board of Health. A Deductible, Copayment, or Coinsurance is not required for immunizations.
- charges for a medically acceptable bone mass measurement to detect low bone mass and to determine the risk of osteoporosis and fractures associated with osteoporosis.
- charges for complications of pregnancy.
- charges for fertility preservation services for individuals receiving Medically Necessary treatment for cancer. These services include: collection and preservation of sperm, unfertilized oocytes, and ovarian tissue, but does not include storage of such unfertilized genetic materials. Treatment for cancer includes surgery, chemotherapy, or radiation that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established may cause impaired fertility.

Hearing Aids and Cochlear Implants for Children

Coverage will be provided for hearing aids and cochlear implants for children 18 years and younger so long as they are Medically Necessary. Such coverage shall include:

- fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of the hearing aids;

- treatment related to hearing aids/cochlear implants, including coverage for habilitation and rehabilitation; and
- external speech processor and controller with necessary replacements every three years (for cochlear implants).

Coverage for hearing aids will be limited to one hearing aid in each ear every three years. Coverage for cochlear implants will be limited to one cochlear implant in each ear with internal replacement (medically or audiologically necessary).

Diabetes

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

Diabetes Equipment and Training:

- blood glucose monitors, including those designed to be used by the legally blind.
- podiatric appliances, including up to two pair of therapeutic footwear per year, for the prevention of complications associated with diabetes.

If determined as Medically Necessary by a treating practitioner/Physician, new or improved treatment and monitoring equipment (approved by the FDA) shall be covered.

The training program for diabetes self-management shall be recognized by the American Diabetes Association and shall be performed by a certified diabetes educator (CDE), a multidisciplinary team coordinated by a CDE (e.g., a dietician, Nurse educator, pharmacist, social worker), or Other Health Professional (e.g., Physician, physician assistant, registered Nurse, registered dietician, pharmacist) determined by his or her licensing board to have recent experience in diabetes clinical and educational issues. All individuals providing training must be certified, licensed or registered to provide appropriate health care services in Texas.

Self-management training shall include the development of an individual plan, created in collaboration with the member that addresses:

- nutrition and weight evaluation;
- medications;
- an exercise regimen;
- glucose and lipid control;
- high risk behaviors;
- frequency of hypoglycemia and hyperglycemia;
- compliance with applicable aspects of self-care;
- follow-up on referrals;
- psychological adjustment;
- general knowledge of diabetes;
- self-management skills;
- referral for a funduscopic eye exam.

This training shall be provided/covered upon the initial diagnosis of diabetes or, the written order of the practitioner/Physician when a change in symptoms or conditions warrant a change in the self-management regime or, the written order of a practitioner/Physician that periodic or episodic continuing education is needed.

Virtual Physician Services

Includes charges for a “telemedicine medical service”, a “telehealth service” or a “teledentistry dental service” for the delivery of real-time medical and health-related services, consultations, and remote monitoring as medically appropriate through audio, video and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.

“Telemedicine medical service” is defined as a health care service delivered by a physician licensed in Texas or provided by a health professional acting under physician supervision and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician using telecommunications or information technology.

“Telehealth service” is defined as a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

"Teledentistry dental service" means a health care service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist’s or health professional’s license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

Includes charges for the delivery of real-time mental health and substance use disorder consultations and services, via secure telecommunications technologies that shall include video capability, telephones and internet, when such

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

Enteral Nutrition

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

Coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism (e.g. disorders of amino acid or organic acid metabolism) including Medically Necessary amino acid based elemental formulas and the services associated with administration of the formulas when prescribed by the treating Physician, regardless of the formula delivery method, that are used for the diagnosis and treatment of: immunoglobulin E and non immunoglobulin E mediated allergies to multiple food proteins; severe food protein-induced enterocolitis syndrome; eosinophilic disorders, as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface functional length, and motility of the gastrointestinal tracts, phenylketonuria (PKU) or an inheritable disease.

HC-COV1682 01-26
ET2

Mental Health and Substance Use Disorder Services

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

Mental Health Residential Treatment Center or Crisis Stabilization Unit means an institution which specializes in the treatment of psychological and social disturbances that are the result of a Mental Health Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a Mental Health Residential Treatment Center or Crisis Stabilization Unit. Coverage for necessary care and treatment in a Mental Health Residential Treatment Center or Crisis Stabilization Unit will be provided as if the care and treatment were provided in a Hospital.

Mental Health Residential Treatment Center for Children and Adolescents means a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

Psychiatric Day Treatment Facility means a Mental Health Residential Treatment Center that is accredited by the Program for Psychiatric Facilities (or its successor) of the Joint Commission on Accreditation of Hospitals; provides treatment of acute mental and nervous disorders, in a structured psychiatric program utilizing individualized treatment plans, for no more than 12 hours in any 24 hour period; and is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

HC-COV1536 01-25
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External Prosthetic Appliances and Devices

The following are specifically excluded orthoses and orthotic devices:

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

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

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

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

Coverage for replacement is limited as follows:

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

The following are specifically excluded external prosthetic appliances and devices:

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

HC-COV1683 01-26
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Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and prosthetics, limited to the lowest cost alternative available that meets prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered. Such coverage shall be provided in a manner determined to be appropriate in consultation with the Physician and the insured.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.

HC-COV662 12-17
ET

The Schedule

The provision “Oral Chemotherapy Medication” shown in the Pharmacy Schedule is hereby replaced with the following:

Oral Chemotherapy Medication

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

SCHEDPHARM90-txet2

The Schedule

The pharmacy schedule is amended to add the following:

Prescription Insulin Drugs

The cost share for each covered prescription insulin drug for you and your Dependents shall not exceed $25 for each 30 day supply ($50 for each 60 day supply or $75 for each 90 day supply) regardless of the amount or type of insulin needed to fill each prescription.

SCHEDPHARM90-txet

Prescription Drug Benefits

Exclusions

- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law. Coverage does include formulas necessary for the treatment of phenylketonuria (PKU) or other inheritable diseases and medications or supplements used to address symptoms of autism spectrum disorder.

HC-PHR838 01-26
ET

Prescription Drug Benefits

Covered Expenses

Prescription Drug List Management

Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. Determination of inclusion of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and decides whether utilization management requirements or other coverage conditions are based on a number of factors which may include clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

Cigna shall offer to each enrollee at the then-current benefit level and until the enrollee's plan renewal date any Prescription Drug Product that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the Prescription Drug Product has been removed from the Prescription Drug List. Cigna may, however, move a Prescription Drug Product to a lower cost-share tier at any time during the plan year.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy (ies) for coverage, or try another covered Prescription Drug Product(s). Please access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

Cigna shall limit changes to the Prescription Drug List that negatively impacts enrollees to the plan's renewal date. Changes to the Prescription Drug List that negatively impact enrollees include removing a Prescription Drug Product from the Prescription Drug List, moving a Prescription Drug Product to a higher cost-share tier or adding a prior authorization, step therapy or quantity limit requirement to the Prescription Drug Product. Cigna may, however, add Prescription Drug Products to the Prescription Drug List, move Prescription Drug Products to a lower cost-share tier or remove any prior authorization or other utilization management requirements from a Prescription Drug Product during the plan year. You will receive at least sixty (60) days notice of any Prescription Drug List change for which Cigna is required to provide notice to enrollees.

HC-PHR638 01-23
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Prescription Drug Benefits

Limitations

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining

prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors. Your Physician may also request a renewal of a prior authorization at least 60 days before it expires. If at all possible, Cigna will review and provide a determination before the existing authorization expires, if the request was received before the expiration.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

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

If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan orally or by submitting a written request stating why the Prescription Drug Product should be covered.

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You or your prescribing Physician may request an exception to a step therapy protocol applicable to a Prescription Drug Product otherwise covered by the plan. The exception request must document why your Physician believes that the preferred Prescription Drug Product alternative(s) are not clinically appropriate for you to use in treatment. Provided you or your Physician submit sufficient information to Cigna with the exception request, Cigna will respond to the exception request within 72 hours of receipt of the request. If your Physician also expresses a reasonable belief that you require the Prescription Drug Product on an emergent basis, then Cigna will respond to the exception request within 24 hours of receipt. Cigna will assess the documentation provided by your Physician against the terms of the applicable exception criteria, which will be made available to the member or prescriber upon request. If Cigna denies the exception request, it will be considered an "adverse determination," as defined by TIC §1369.0546, and you may appeal the determination. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card. These requirements do not apply to prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions.

Supply Limits

Prescription drug coverage shall provide for synchronization of prescription drug refills on at least one occasion per insured per year, provided all of the following conditions are met:

- the prescription drugs are covered by the plan's clinical coverage policy or have been approved by a formulary exceptions process;
- the prescription drugs are maintenance medications as defined by the plan and have available refill quantities at the time of synchronization;
- the medications are not Schedule II, III or IV controlled substances;

- you or your Dependent meet all utilization management criteria to the prescription drugs at the time of synchronization;
- the prescription drugs are of a formulation that can be safely split into short-fill periods to achieve synchronization;
- the prescription drugs do not have special handling or sourcing needs as determined by the plan that require a single, Designated Pharmacy to fill or refill the prescription; and
- you agree to the synchronization.

When necessary to permit synchronization, the plan shall apply a prorated daily cost-sharing rate to any medication dispensed by a Network Pharmacy. No dispensing fees shall be prorated, and all dispensing fees shall be based on the number of prescriptions filled or refilled.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Prescription Eye Drops

Coverage for a refill for prescription eye drops shall be provided if the:

- refill is requested no earlier than the 21st day after a 30 day supply is dispensed, the 42nd day after a 60 day supply is dispensed or the 63rd day after a 90 day supply is dispensed;
- prescribing Physician indicates on the original prescription that additional quantities are needed;
- refill requested does not exceed the number of additional quantities needed;
- refill is dispensed within the prescribed dosage period; and
- prescription eye drops are a covered benefit under the plan.

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

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

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

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

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician relies on the coverage policies maintained by Cigna or the Review Organization. Coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines and is recognized for the treatment of prescribed indication in The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information or supported by articles in accepted, peer-reviewed medical literature.
- the following services are excluded from coverage regardless of clinical indications except as may be covered under the “Reconstructive Surgery” benefit: macromastia surgery or gynecomastia surgery; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral and cranial therapy; dance therapy; movement therapy; applied

kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

- infertility and other treatment to assist in achieving pregnancy, including surgical and medical treatment, devices, and infertility drugs; and fertility preservation, including retrieval, cryopreservation, and storage of eggs, sperm, and embryos, other than as described in Covered Expenses.
- reversal of male and female voluntary sterilization procedures.
- hearing aids for individuals age 19 and older, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). This does not include an external speech processor and controller with necessary replacements every three years (for cochlear implants) for individuals 18 years and younger. A hearing aid is any device that amplifies sound.
- health and beauty aids, cosmetics and dietary supplements. This does not include formulas necessary for the treatment of phenylketonuria (PKU) or other inheritable diseases and medications or supplements used to address symptoms of autism spectrum disorder.

HC-EXC648 01-26
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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 pursing any subrogation or recovery rights by providing requested information.

HC-SUB84 10-16

Payment of Benefits

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

HC-POB208 01-26
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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
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When You Have A Complaint Or An Adverse Determination 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.

When You Have a Complaint

We are here to listen and help. If you have a complaint regarding a person, a service, the quality of care, a rescission of coverage, or contractual benefits not related to Medical Necessity, you can call our toll-free number and explain your concern to one of our Customer Service representatives. A complaint does not include: a misunderstanding or problem of misinformation that can be promptly resolved by Cigna by clearing up the misunderstanding or supplying the correct information to your satisfaction; or you or your provider's dissatisfaction or disagreement with an Adverse Determination. You can also express that complaint in writing. Please call us at the Customer Service toll-free number that appears on your Benefit Identification card, explanation of benefits or claim form, or write to us at the following address:

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

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your complaint, we will send you a letter acknowledging the date on which we received your complaint no later than the fifth working day after we receive your complaint. We will respond in writing with a decision 30 calendar days after we receive a complaint 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, (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, or your treating Physician, will decide if an expedited appeal is necessary. When a complaint is expedited, we will respond orally with a decision within the earlier of: 72 hours; or one working day, followed up in writing within 3 calendar days.

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

Complaint Appeals Procedure

To initiate an appeal of a complaint resolution decision, you must submit a request for an appeal in writing 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 complaint appeal request will be conducted by the Complaint Appeals Committee, which consists of at least three people. Anyone involved in the prior decision, or subordinates of those people, may not vote on the Committee. 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 within five working days after the date we receive your request for a Committee review and schedule a Committee review. 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 complaint 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 non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer or your treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within the earlier of: 72 hours; or one working day, followed up in writing within three calendar days.

When You Have an Adverse Determination Appeal

An Adverse Determination is a decision made by Cigna that the health care service(s) furnished or proposed to be furnished to you is (are) not Medically Necessary or clinically appropriate. An Adverse Determination also includes a denial by Cigna of a request to cover a specific prescription drug prescribed by your Physician. If you are not satisfied with the Adverse Determination, you may appeal the Adverse Determination orally or in writing. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. We will acknowledge the appeal in writing within five working days after we receive the Adverse Determination Appeal request.

Your appeal of an Adverse Determination will be reviewed and the decision made by a health care professional not involved in the initial decision. The health care professional should hold a Texas license. 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.

We will respond in writing with a decision within 30 calendar days after receiving the Adverse Determination appeal request.

You may request that the Adverse Determination appeal process be expedited if it relates to: (a) emergency denials, (b) denials of care for life-threatening conditions, (c) denials of continued stays for hospitalized enrollees; and (d) denial of prescription drugs or intravenous infusions for which the Member is receiving benefits under the Agreement; or (e) step therapy requests.

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 or your treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within the earlier of: 72 hours; or one working day, followed up in writing within three calendar days.

In addition, your treating Physician may request in writing a specialty review within 10 working days of our written decision. The specialty review will be conducted by a Physician in the same or similar specialty as the care under consideration. The specialty review will be completed and a response sent within 15 working days of the request. Specialty review is voluntary. If the specialty reviewer upholds the initial Adverse Determination and you remain dissatisfied, you are still eligible to request a review by an Independent Review Organization.

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 Adverse Determination appeal process or if you feel your condition is life-threatening, you may request that your appeal be referred to an Independent Review Organization. In addition, your treating Physician may request in writing that Cigna conduct a specialty review. The specialty review request must be made within 10 days of receipt of the Adverse Determination appeal decision letter.

Cigna must complete the specialist review and send a written response within 15 days of its receipt of the request for specialty review. If the specialist upholds the initial Adverse Determination, you are still eligible to request a review by 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 and the decision to use the process is voluntary. 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. You will receive detailed information on how to request an Independent Review and the required forms you will need to complete with every Adverse Determination notice.

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

Appeal to the State of Texas

You have the right to contact the Texas Department of Insurance for assistance at any time for either a complaint or an Adverse Determination appeal. The Texas Department of Insurance may be contacted at the following address and telephone number:

Texas Department of Insurance
333 Guadalupe Street
PO Box 149104
Austin, TX 78714-9104
1-800-252-3439

If you are not fully satisfied with the decision of Cigna's internal 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 (IRO). The IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant’s rights to any other benefits under the plan.

There is no charge for you to initiate an external review. Cigna and your benefit plan will abide by the decision of the IRO.

In order to request a referral to an IRO, the reason for the denial must be based on 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 four months of your receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna's reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the external review shall be completed within 72 hours.

Notice of Benefit Determination on Appeal

Every notice of an appeal decision 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 denial decision 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 decision 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 Under Federal Law

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. If your Complaint is expedited, there is no need to complete the complaint appeal 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.

However, no action may be brought at all unless brought within three years after a claim is submitted for In-Network services.

HC-APL477 01-25
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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.

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
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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.

HC-DFS1840 01-23
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Vermont Residents

Rider Eligibility: Each Employee who is located in Vermont

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

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

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

HC-ETVTRDR

Important Notices

Vermont Mandatory Civil Unions Endorsement for Health Insurance

Purpose:

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

Definitions, Terms, Conditions and Provisions

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

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

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

Terms that mean or refer to family relationships arising from a marriage, such as “family,” “immediate family,” “dependent,” “children,” “next of kin,” “relative,” “beneficiary,” “survivor” and any other such terms include family relationships created by a civil union established according to Vermont law.

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

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

Caution: Federal Rights May or May Not Be Available

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

HC-IMP217 05-17

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The Schedule

Any deductible or coinsurance applicable to annual routine or diagnostic mammograms does not apply.

SCHED-VTET

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.

Exclusions, Expenses Not Covered and General Limitations

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

  "Experimental or investigational services" means health care items or services that are:

  - not generally accepted by informed health care providers in the United States as effective in treating the condition, illness or diagnosis for which their use is proposed, or are;
  - not proven by medical or scientific evidence to be effective in treating the condition, illness or diagnosis for which their use is proposed.

HC-EXC589 01-25
ET1

When You Have A Complaint Or An Appeal (Grievance)

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.

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, or a recession of coverage, you are welcome to 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.

While a level one appeal is a required part of the process, a level two appeal is completely voluntary. For example, if a level one appeal is not resolved to your satisfaction, you may choose to make an external appeal to an Independent Panel of Mental Health Care Providers or to an Independent Review Organization, as described later in this provision, rather than pursuing Cigna’s voluntary level two appeal process.

The voluntary level two appeal review will be done without deference to:

- the initial adverse benefit determination; or
- the adverse determination of a level one appeal.

The appeal review takes into account all comments, documents, records, and other information relating to the appeal that you submit, regardless of whether that information was submitted or considered:

- in the initial benefit determination (for a level one or voluntary level two appeal); or
- during the level one appeal (for a voluntary level two appeal).

Additional assistance is also available from the Vermont Department of Financial Regulation, as described later in this provision.

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, including any written comments, documents, records and other information relating to your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Reasonable accommodations will be made to help a person with a disability participate in the appeal process. Additionally, if English is not your primary language, we will provide you with information about how to file an appeal and how to participate in the appeal process, in your primary language, upon your request. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form. We will document the appeal for you and provide copies of that documentation to you, or to your representative.

For any appeal related to an adverse benefit determination, should a reversal of that decision be made during any step of the appeal process, Cigna will promptly authorize or otherwise arrange for coverage of a covered service that was denied or restricted. Neither you nor your treating provider will be liable for any services provided before notification to you of the adverse benefit determination and the final outcome of any appeal or independent external review.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. This person will also not be the subordinate of any individual who was involved with the initial decision or other issue that is the subject of the appeal. Appeals involving an adverse benefit determination that is based in whole or in part on a medical judgment will be considered by a health care professional who is a clinical peer of your treating provider.

You may request that we identify to you any clinical expert whose advice we obtained in connection with your adverse benefit determination, regardless of whether or not that expert's advice was relied on when the determination was made. Any clinical expert we ask to consult with us regarding your level one appeal will not be the same clinical expert (if any) we consulted with regarding the adverse benefit determination that is the subject of your appeal, or the subordinate of that clinical expert (if any).

A Cigna medical director or his or her designee will offer to directly communicate with your treating provider, or your treating provider's designee, before the appeal is decided.

You will have reasonable access to, and may obtain copies of, all documents, records and other information relevant to your appeal upon request and free of charge, within two business days. In the case of a concurrent or urgent pre-service review, you will have access to or may obtain the materials immediately upon request.

Level One Urgent, Pre-Service Appeal

For an urgent pre-service level one appeal, we will orally notify you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 72 hours after we receive the appeal. We will send written confirmation of the determination to you and your treating provider (if known), within 24 hours of our oral notification to you.

Mental health/substance abuse and pharmacy benefit requests are generally considered urgent under Vermont regulatory requirements.

Level One Non-Urgent, Pre-Service Appeal

For a non-urgent pre-service level one appeal, we will send written confirmation to you and your treating provider (if known) of our determination as soon as is

possible based on your medical condition, but in no case later than 30 calendar days after we receive the appeal.

Level One Concurrent Review Appeal

For a level one appeal related to a request to continue or extend a course of treatment (i.e. a concurrent review), we will orally notify you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 24 hours after we receive the appeal. We will send written confirmation of the determination to you and your treating provider (if known), within 24 hours of our oral notification to you.

Level One Post-Service Appeal

For a level one post-service appeal, we will send written confirmation to you and your treating provider (if known) of our determination within a reasonable time period, but in no case later than 60 calendar days after we receive the appeal.

Level One Appeal Not Related to an Adverse Benefit Determination

For a level one appeal not related to an adverse benefit determination, we will send written confirmation to you within 60 calendar days after we receive the appeal.

Voluntary Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a voluntary second review. To start a voluntary level two appeal, follow the same process required for a level one appeal. If you decide to pursue a voluntary second level appeal review, that decision has no effect on your right to any other benefits under this plan.

The voluntary level two appeal review will be done without deference to the initial adverse benefit determination or to the adverse determination of a level one appeal.

Neither you nor your provider acting on your behalf are responsible for any fees or costs associated with a voluntary level two appeal, should you choose to pursue one.

You will have reasonable access to, and may obtain copies of, all documents, records and other information relevant to your appeal upon request and free of charge, within two business days. In the case of a concurrent or urgent pre-service review, you will have access to or may obtain the materials immediately upon request.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone who is a member of the Committee may not: have been involved in the initial adverse benefit determination or other issue that is the subject of the appeal; have been involved in the adverse determination of the level one appeal; or be the subordinate of any person involved with the initial determination or other issue that is the subject of the appeal or the level one appeal. 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 request that we identify to you any clinical expert whose advice we obtained in connection with your adverse benefit determination, regardless of whether or not that expert’s advice was relied on when the determination was made. Any clinical expert we ask to consult with us regarding your voluntary level two appeal will not be the same clinical expert (if any) we consulted with regarding the adverse benefit determination that is the subject of your appeal or your level one appeal, or the subordinate of that clinical expert (if any).

For a voluntary level two appeal we will acknowledge in writing that we have received your request and schedule a Committee review. You will be consulted regarding setting the meeting date for a voluntary second level appeal review. You may present your situation to the Committee in person or by conference call; however, participating in person or via telephone is not a requirement for the voluntary second level appeal meeting to proceed.

Voluntary Level Two Urgent, Pre-Service Appeal

For an urgent pre-service voluntary level two appeal, we will orally notify you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 72

hours after we receive the appeal. We will send written confirmation of the determination to you and your treating provider (if known), within 24 hours of our oral notification to you.

Mental health/substance abuse and pharmacy benefit requests are generally considered urgent under Vermont regulatory requirements.

Voluntary Level Two Non-Urgent, Pre-Service Appeal

For a non-urgent pre-service voluntary level two appeal, we will send written confirmation to you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 30 calendar days after we receive the appeal.

Voluntary Level Two Concurrent Review Appeal

For a voluntary level two appeal related to a request to continue or extend a course of treatment (i.e. a concurrent review), we will orally notify you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 24 hours after we receive the appeal. We will send written confirmation of the determination to you and your treating provider (if known), within 24 hours of our oral notification to you.

Voluntary Level Two Post-Service Appeal

For a voluntary level two post-service appeal, we will send written confirmation to you and your treating provider (if known) of our determination within a reasonable time period, but in no case later than 60 calendar days after we receive the appeal.

Voluntary Level Two Appeal Not Related to an Adverse Benefit Determination

For a voluntary level two appeal not related to an adverse benefit determination, we will send written notification to you within 60 calendar days after we receive the appeal.

External Review Procedure For Mental Health/Substance Abuse Issues

If you are dissatisfied with either a level one appeal decision or a voluntary level two appeal decision, you may request an External Review of your issue by an Independent Panel of Mental Health Care Providers (IP). To start the External Review by an IP, you, your mental health care provider or your representative on your behalf, must file a written request with Cigna and the IP. You must include your consent for Cigna to release confidential patient files to the IP. The IP address is:

Independent Panel of Mental Health Care Providers
Department of Financial Regulation
89 Main Street
Montpelier, VT 05620-3101
800-631-7788(toll-free) or 802-282-2900

When Cigna receives your request for an External Review, Cigna will send the file supporting the initial decision and the appeal decision(s) to the IP within: 24 hours of receiving the request in emergency situations; and within five working days of receiving the request in all other situations.

The IP may address inquiries to any of the parties (you, your mental health care provider or your authorized representative, or Cigna) and may set a reasonable time period for a response. If Cigna does not provide all necessary information in the required time periods, the delay will result in a presumption in your favor and will not delay the IP's review of the issue. The IP also has the authority to request any or all of the parties to meet with the IP. The IP will make its review decision within 24 hours of receiving all necessary information in emergency situations; and within 15 working days in all other situations. The IP will send its decision by mail or facsimile to Cigna and to the person who filed the request for External Review. Emergency decisions will be communicated by telephone, facsimile or delivered by express mail as appropriate. Cigna is required to abide by the IP's decision. If you have a complaint about a matter that is not related to Medical Necessity or clinical appropriateness, you may file a consumer complaint with the Insurance Consumer Services Division at the following address:

Insurance Consumer Services Division
Department of Financial Regulation
89 Main Street, Drawer 20
Montpelier, VT 05620-3101
802.828.3302

External Appeal Procedure For Non-Mental Health/Substance Abuse Issues

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 dissatisfied with a level one appeal or a voluntary level two appeal decision, you may request an External Review of your issue by an Independent Review Organization (IRO).

You (or your authorized representative or your provider on your behalf) may file a written request for External Review within 90 days from the date you receive Cigna's final, written appeal decision. External Appeals for non-Mental Health/Substance Abuse issues may be requested for the following reasons:

- The health care service is a covered benefit that Cigna has determined to be not Medically Necessary.
- A limitation is placed on the selection of a health care provider that you claimed to be inconsistent with limits imposed by this plan and any applicable laws and regulations.
- The health care treatment has been determined to be experimental or investigational or an off-label use of a drug.

The written request for External Review must be filed with the Vermont Department of Financial Regulation at the following address:

External Appeals Program
Vermont Department of Financial Regulation
89 Main Street, Montpelier, VT 05620-3101
Telephone: 800-631-7788 (toll-free) or 802-828-2900

The insured must file on a form provided by the Department and include the $25 fee or a request for a waiver or reduction of the fee, general release of medical records relevant to the appeal, identification of insurer and a copy of the denial level from the relevant level of appeal. An oral request will also be accepted if made within the 90-day period provided that the request is confirmed in writing on the state request form within 10 calendar days. The External Appeal program is a voluntary program.

Once notified by the Department that the External Appeal has been accepted for review by an IRO, Cigna must submit all information relevant to the appeal, including: the review criteria used in making the decision; copies of any applicable policies or procedures; and copies of all medical records considered in making the decision in the appeal process. Cigna may request an extension of up to 10 days to submit information and documentation, granted by the Department for good cause.

Cigna must pay the costs of the External Appeal to the Department within 30 days of notification of the reasonable and necessary costs of the review by the IRO.

The Department will provide the request form for an External Appeal. An oral request will also be accepted if made within the 90-day period provided that the request is confirmed in writing on the state request form within 10 calendar days. Within five working days of receiving the External Appeal request the Department will process the form and materials, and accept the appeal for review by an IRO after determining: that you are or were insured; the service is a covered service under the plan; the External Appeal involves an appealable decision; you have exhausted the internal process; and all information has been provided.

The Vermont Department of Financial Regulation ("Department") will notify you when the External Appeal submission is complete, and whether the External Appeal has been accepted for review by an IRO. Cigna must submit any required documentation within 10 calendar days from the date Cigna receives the request notice. Cigna may request a 10-calendar day extension for good cause. You may have an extension for any reason.

The Department shall provide copies of documentation (and follow-up information) to you and to Cigna; each will have three working days to file responsive documentation with the Department.

The Department will assign the External Appeal on a rotating basis to an IRO for clinical review.

The Department will review the determination of the IRO and then issue the determination to you and to Cigna, which will be binding on Cigna but not on you.

The IRO will conduct a full review, and may request any additional information from you, Cigna, or the Department. The IRO will complete the review, and forward its written determination to the Department within five calendar days from receipt if the External Appeal involves emergency or urgently needed care; and 30 calendar days from receipt for all other External Appeal requests. The IRO's written determination will include the clinical rationale for the determination. The IRO may request an extension from the Commissioner.

Assistance from the state of Vermont

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

Health Insurance Consumer Services Division
Department of Financial Regulation
89 Main Street, Montpelier, VT 05620-3101
800-631-7788 (toll-free) or 802-828-2900

The Office of Health Care Advocate's telephone hotline service can also provide help to Vermonters who have problems or questions about health care and health insurance. Contact them at:

Office of Health Care Advocate
264 North Winooski Avenue
Burlington, VT 05402
Telephone: 888-917-7787 or 802-863-2316
TTY: 888-884-1955 or 802-863-2473

Applies to All Issues

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; 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-APL471 01-25
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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

Covered Expenses

- charges made for a health care service provided to a covered person through telemedicine store and forward technology if:
  - the plan provides coverage of the health care service when provided in person by the provider;
  - the health care service is Medically Necessary; and
  - the health care service is a service recognized as an Essential Health Benefit.

If the service is provided through store and forward technology there must be an associated office visit between the covered person and the referring health care provider. Telemedicine can be utilized for the associated office visit.

Telemedicine means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis,

consultation, or treatment. Telemedicine does not include the use of audio-only telephone, facsimile, or email.

Reimbursement of store and forward technology is available only for those covered services specified in the negotiated agreement between the health carrier and the health care provider.

An originating site for a telemedicine health care service includes a: Hospital; Rural health clinic; Federally qualified health center; Physician's or other health care provider's office; Community mental health center; Skilled Nursing Facility; or Renal dialysis center, except an independent renal dialysis center or your home or any location determined by the individual receiving the service.

Any originating site may charge a facility fee for infrastructure and preparation of the patient. Reimbursement must be subject to a negotiated agreement between the originating site and the health carrier.

A distant site or any other site not identified in the above bullets may not charge a facility fee.

Telemedicine or store and forward technology health service is subject to all terms and conditions of the plan including, but not limited to, utilization review, prior authorization, Deductible, Copayment, or Coinsurance requirements that are applicable to coverage of a comparable health care service provided in person.

A health carrier is not required to reimburse: an originating site for professional fees; a provider for a health care service that is not a covered benefit under the plan; or an originating site or health care provider when the site or provider is not a contracted provider under the plan.

Distant site means the site at which a Physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine.

Originating site means the physical location of a patient receiving health care services through telemedicine.

Store and forward technology means use of an asynchronous transmission of a covered person's medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email.

Prescription Drug Benefits

Limitations

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.

HC-PHR878 01-26
ET2

Definitions

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old.
  - 26 years old, but less than 30, unmarried, enrolled in school as a full-time student and primarily supported by you.
  - 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 or student will continue until the last day of the calendar year in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent or Dependent spouse unless the Dependent or Dependent spouse declines Employee coverage. A child under age 26 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee.

No one may be considered as a Dependent of more than one Employee.

HC-DFS1758 01-22
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – West Virginia Residents

Rider Eligibility: Each Employee who is located in West Virginia

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

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

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

HC-ETWVRDR

Important Information

Rebates and Other Payments

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

Coupons, Incentives and Other Communications

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

HC-IMP445 01-25
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Limitations

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. Specialty Prescription Drug Products can come from any Network Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products.

HC-PHR806 01-25
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Wyoming Residents

Rider Eligibility: Each Employee who is located in Wyoming

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

HC-ETWYRDR

Covered Expenses

- charges for cancer screening tests, including: a pelvic examination, pap smear and clinical breast cancer examination, including a mammogram; a prostate examination and laboratory tests; and a colorectal cancer examination and laboratory tests for any non-symptomatic person.

HC-COV1608 01-25
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