JPS Health Network

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2024

ETALLM24A
3332385

This document printed in December, 2023 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: JPS Health Network
Rider Eligibility: Each Employee as noted within this certificate rider
Policy No. or Nos.: 3332385
Effective Date: January 1, 2024

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

IMPORTANT INFORMATION

For Residents of States other than the State of Texas:

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

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

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

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

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

Geneva Cambell Brown, Corporate Secretary

HC-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

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

CERTIFICATE RIDER – California Residents

Rider Eligibility: Each Employee who is located in California

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

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

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

HC-ETCARDR

Definitions

Dependent

The term child means a child born to you, a child legally adopted by you from the date the child is placed in your physical custody prior to the finalization of the child's adoption, or a child supported by you pursuant to a court order (including a qualified medical child support order).

HC-DFS1023 10-16
ET4

Primary Care Physician

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

HC-DFS167 04-10
V2-ET1

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

CERTIFICATE RIDER – Colorado Residents

Rider Eligibility: Each Employee who is located in Colorado

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

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

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

HC-ETCORDR

Definitions

Dependent

Dependents include:

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

HC-DFS1667 01-22
ET

Emergency Service Provider

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

HC-DFS236 04-10
V1-ET

Employee

The term Employee means a full-time Employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 0 hours a week for the Employer. The term Employee may include officers, managers and Employees of the Employer, the bona fide volunteers if the Employer is an Emergency Service Provider, the partners if the Employer is a partnership, the officers, managers, and Employees of subsidiary or affiliated corporations of a corporation Employer, and the individual proprietors, partners, and Employees of individuals and firms, the business of which is controlled by the insured Employer through stock ownership, contract, or otherwise.

HC-DFS1096 01-18
ET1

Employer

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

HC-DFS1594 01-21
ET

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

CERTIFICATE RIDER – Connecticut Residents

Rider Eligibility: Each Employee who is located in Connecticut

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

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

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

HC-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 – Florida Residents

Rider Eligibility: Each Employee who is located in Florida

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

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

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

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

HC-ETFLRDR

Eligibility - Effective Date

Dependent Insurance

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included. For your Dependents to be insured for these benefits, you must elect the Dependent insurance for yourself no later than 30 days after you become eligible.

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

HC-ELG326 03-21
ET

Covered Expenses

- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: a baseline mammogram for women ages 35 through 39; a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; a mammogram every year for women age 50 and over; and one or more

mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician's recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.

- charges made for diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint. Appliances and non-surgical treatment including for orthodontia are not covered.
- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.
- charges for general anesthesia and hospitalization services for dental procedures for an individual who is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.
- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.
- charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: have vertebral abnormalities; are receiving long-term glucocorticoid (steroid) therapy; have primary hyperparathyroidism; have a family history of osteoporosis; and/or are estrogen-deficient individuals who are at clinical risk for osteoporosis.
- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be Medically Necessary by the Physician and in consultation with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.
- charges for newborn and infant hearing screening as well as any medically necessary follow-up evaluations leading to diagnosis and subsequent medically necessary treatment of a diagnosed hearing impairment.
- charges for the coverage of child health supervision services from birth to age 16. Child health supervision services are physician-delivered or supervised services that include periodic visits which include a history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests.

Medical Conversion Privilege

For You and Your Dependents

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

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

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

Employees Entitled to Convert

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

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

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

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

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

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

Overinsured

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

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

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

Converted Policy

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

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

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

HC-CNV28 04-14
V1-ET

Exclusions, Expenses Not Covered and General Limitations

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

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

HC-EXC528 01-24
ET

Medical Benefits Extension Upon Policy Cancellation

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

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date a succeeding carrier agrees to provide coverage without limitation for the disabling condition;

- the date you are no longer Totally Disabled;
- 12 months from the date the policy is canceled; or
- for pregnancy, until delivery.

Totally Disabled

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

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

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

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

HC-BEX42 04-11
ET

Definitions

Dependent – For Medical Insurance

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

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

HC-DFS1685 01-23
ET

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

CERTIFICATE RIDER – Georgia Residents

Rider Eligibility: Each Employee who is located in Georgia

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

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

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

HC-ETGARDR

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

CERTIFICATE RIDER – Illinois Residents

Rider Eligibility: Each Employee who is located in Illinois

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

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

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

HC-ETILRDR

The Schedule

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

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

SCHEDIL-ETC

The Schedule

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

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

SCHED IL ET-1

The Schedule

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

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

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

SCHED IL ET-2

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

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

HC-PAC111 01-20
V1 ET

Covered Expenses

- charges for ambulatory surgical facilities and associated anesthesia charges for dental care that is provided to a covered individual who: is a child age 6 or under; has a medical condition that requires hospitalization or general anesthesia for dental care; or is disabled.
- charges made, and anesthetics provided by a dentist with a permit by the IL Department of Financial and Professional Regulation to administer general anesthesia, deep sedation, or conscious sedation in conjunction with dental care that is provided to an insured in a dental office, oral surgeon's office, Hospital or ambulatory surgical treatment center if the individual is under age 26 and has been diagnosed with an Autism Spectrum Disorder or a Developmental Disability and has made 2 visits to the dental care provider prior to accessing this coverage.

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

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

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

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

- it is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
- it is manifested before the individual reaches age 22;
- it is likely to continue indefinitely; and
- it results in substantial functional limitations in 3 or more of the following areas of major life activity: self-care, language, learning, mobility, self-direction, and capacity for independent living.

- charges made for or in connection with low-dose mammography screening including breast tomosynthesis for detecting the presence of breast cancer. Coverage shall include: a baseline mammogram for women ages 35 to 39; an annual mammogram for women age 40 and older; and mammograms at intervals considered Medically Necessary for women less than age 40 who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors. Coverage also includes a comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches as well as a screening MRI when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches.
- low dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device and image receptor, with radiation exposure delivery of less than one rad per breast for two views of an average sized breast. This term also includes digital mammography and includes breast tomosynthesis. The term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.
- charges made for complete and thorough clinical breast exams performed by a Physician licensed to practice medicine in all its branches, an advanced practice nurse who has a collaborative agreement with a collaborating Physician that authorizes breast examinations, or a Physician assistant who has been delegated authority to provide breast examinations. Coverage shall include such an exam at least once every three years for women ages 20 to 40; and annually for women 40 years of age or older.
- charges for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including, but not limited to the use of intravenous immunoglobin therapy.

Virtual Care

Virtual Physician Services

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

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

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

Includes bundled health care services delivered through a multi-disciplinary team of mental health professionals to individuals who are experiencing severe and persistent symptoms from a serious mental illness.

Donated Breast Milk

If the covered person is an infant under the age of 6 months, and a licensed medical practitioner prescribes the milk for the covered person, and all of the following conditions are met:

- the milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking Association of North America or is licensed by the Department of Public Health;
- the infant's mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated;
- the milk has been determined to be Medically Necessary for the infant; and
- one or more of the following applies:
  - the infant's birth weight is below 1,500 grams;
  - the infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis;
  - the infant has infant hypoglycemia;
  - the infant has congenital heart disease;
  - the infant has had or will have an organ transplant;
  - the infant has sepsis;

- the infant has any other serious congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the infant;

- one or more of the following applies:
  - the child has spinal muscular atrophy;
  - the child's birth weight was below 1,500 grams and he or she has long-term feeding or gastrointestinal complications related to prematurity;
  - the child has had or will have an organ transplant; or
  - the child has a congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the child.

Long-term Antibiotic Therapy

Coverage for long-term antibiotic therapy, including necessary office visits and ongoing testing, for a person with a tick-borne disease when determined to be Medically Necessary and ordered by a Physician licensed to practice medicine in all its branches after making a thorough evaluation of the person's symptoms, diagnostic test results, or response to treatment. An experimental drug must be covered as a long-term antibiotic therapy if it is approved for an indication by the United States Food and Drug Administration. A drug, including an experimental drug, shall be covered for an off-label use in the treatment of a tick-borne disease if the drug has been approved by the United States Food and Drug Administration.

Skin Cancer Screening

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

HC-COV1234 01-22
ET3

Durable Medical Equipment

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

HC-COV1035 01-21
ET

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-COV1204 01-22
ET3

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

CERTIFICATE RIDER – Kansas Residents

Rider Eligibility: Each Employee who is located in Kansas

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

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

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

HC-ETKSRDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you already have insured Dependents, any additional Dependent children born while such Dependent Insurance is in effect will automatically be enrolled. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Any newborn child adopted by you while you are insured will become insured on the date of his birth and continue for 31 days provided that the petition for adoption is filed within the first 31 days. Any other child adopted by you shall be from the date of placement in the home for the purpose of adoption or the date of petition for adoption. The number of days between the date of placement and the date of the petition shall not exceed 280.

HC-ELG248 01-19
ET

Covered Expenses

- charges for abortion when a Physician certifies in writing that the pregnancy would endanger the life of the mother.

HC-COV895 01-20
ET1

Covered Expenses

Autism Spectrum Disorders

- charges made for all generally recognized services prescribed in relation to Autism Spectrum Disorder for Dependent children. Such coverage must be prescribed by a Physician, in a treatment plan and shall include evaluation and assessment services; applied behavior analysis; speech therapy; occupational therapy; and physical therapy.
- Autism Spectrum Disorder means a neurobiological disorder, an illness of the nervous system, which includes Autistic disorder, Asperger's disorder, pervasive developmental disorder not otherwise specified, Rett's disorder and childhood disintegrative disorder.
- charges made for diagnostic mammograms and Papanicolaou laboratory screening tests, including services performed at a certified mobile facility.

Mammograms

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

HC-COV895 01-20
ET2

Definitions

Review Organization

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

HC-DFS808 12-15
V2 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

Covered Expenses

- charges for cochlear implants for persons age 2 and over with the diagnosis of profound sensorineural deafness or postlingual deafness in adults. Cochlear implants for children under age 2 will be covered when, upon review, they are determined to be Medically Necessary.
- charges for the diagnosis and treatment of Autism Spectrum Disorders:

  treatment for Autism Spectrum Disorders includes medical care, habilitative or rehabilitative care, pharmacy if covered by the plan, psychiatric care, psychological care, therapeutic care, and applied behavior analysis prescribed or ordered by a licensed health professional.

  coverage is not subject to visit limits. Coverage is not subject to copayments, deductibles, or coinsurance that is less favorable than those applied to other covered services.

  Cigna may request utilization review of the treatment once every 12 months, unless Cigna and the covered person's licensed Physician, psychiatrist, or psychologist agree that a more frequent review is necessary
- charges for a telehealth consultation provided the treating Physician or other provider facilitating the use of telehealth ensures that: informed consent of the patient or another person with authority to make the health care treatment decision for the patient, is obtained before covered services are provided through telehealth; and that the confidentiality of the patient's medical information and quality of care protocols are maintained. Telehealth means the use of interactive, audio, video or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data and medical education.
- charges for the necessary care and treatment of medically diagnosed inherited metabolic diseases. Coverage must include amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases provided that the amino acid products are prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic diseases, and are administered under the direction of a Physician.

HC-COV162 05-12
V3-ET1

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

Covered Expenses

- charges for electronic imaging/telemedicine health care services, including, but not limited to, diagnostic testing and treatment. The Physician must be physically present with the patient and communicating with a Physician at the facility receiving the transmission. Payment shall not be less than 75% of the reasonable and customary payment received for an intermediate office visit. These electronic/telemedicine benefits are subject to utilization review requirements.
- charges for treatment of severe mental illness, on the same basis as other sickness covered under the plan. "Severe mental illness" includes any of the following:
  - 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;
  - Tourette's Disorder.

Autism Spectrum Disorder

Charges for the diagnosis and treatment of Autism Spectrum Disorders, including applied behavioral analysis, in individuals less than 17 years of age. 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;
- 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.

HC-COV190 04-10
V1-ET1

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.

HC-TRM81 04-10

V1-ET1

Definitions

Dependent

The term child includes any grandchild of yours provided such child is under 26 years of age and is in your legal custody and resides with you or any grandchild of yours who is in your legal custody and resides with you, and is incapable of self-sustaining employment by reason of mental or physical handicap which existed prior to the child's 26th birthday.

HC-DFS427 04-10

V1-ET1

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.

SCHEDMI-ETC

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-EXC490 01-22
ET1

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

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

CERTIFICATE RIDER – Minnesota Residents

Rider Eligibility: Each Employee who is located in Minnesota

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

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

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

HC-ETMNRDR

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- expenses for which another party may be responsible as a result of having caused or contributed to the Injury or Sickness. If you incur a Covered Expense for which, in the opinion of Cigna, another party may be liable, Cigna may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to Cigna the lesser of:
  - The amount actually paid for such Covered Expenses by Cigna; or
  - The amount you actually receive from the third party for such Covered Expenses;

  at the time that the third party's liability for medical expenses is determined and satisfied, whether by settlement, judgment, arbitration or award or otherwise.
- 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.

Cigna's claim rights under this provision will be valid only if you are fully compensated for your loss. Your costs, disbursements, attorney fees and other expenses incurred to obtain recovery from the third party will be subtracted from the amount of Cigna's claim right.

Cigna will only exercise its claim rights if the amount received by you is specifically identified in the settlement or judgment as amounts paid for medical expenses.

Subrogation/Right Of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

1. 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 of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
2. 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 of the benefits provided by the plan.

Cigna's claim rights under this provision will be valid only if you are fully compensated for your loss. Your costs, disbursements, attorney fees and other expenses incurred to obtain recovery from the third party will be subtracted from the amount of Cigna's claim right.

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 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 said attorney, insurance carrier or other party has been notified by the plan or its agents;
- 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. 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.

HC-SUB1 04-10

V3-ET

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- 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 or similar coverage.

The plan's subrogation right applies only after the Participant has received a full recovery from another source.

The plan's subrogation right is subject to subtraction for actual monies paid to account for the pro rata share of the Participant's costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless the plan is separately represented by an attorney. If the plan is separately represented by an attorney, the plan and the Participant, by their attorneys, may enter into an agreement regarding allocation of the Participant's costs, disbursements, and reasonable attorney fees and other expenses. If the plan and Participant cannot reach agreement on allocation, the plan and Participant shall submit the matter to binding arbitration.

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.

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 of any benefits paid under the plan. 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 of the benefits provided by the plan.

Cigna's claim rights under this provision will be valid only if you are fully compensated for your loss. Your costs, disbursements, attorney fees and other expenses incurred to obtain recovery from the third party will be subtracted from the amount of Cigna's claim right.

Additional Terms

- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

HC-SUB115 05-18

ET

Termination of Insurance

Employees

Termination of Insurance

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance;
- the last day for which you have made any required contribution for the insurance;
- the date the policy is canceled;
- the date your Active Service ends except as described below.

HC-TRM199 01-21
ET2

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.

Important Information About Your Medical Plan

Direct Access for OB/GYN Services

Female insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for covered OB/GYN services. There is no requirement to obtain an authorization of care from your Primary Care Physician (if you have selected one) for visits to the Participating Provider of your choice for those services defined by the published recommendations of the accreditation council for graduate medical education for training an obstetrician, gynecologist or obstetrician/gynecologist, including but not limited to diagnosis, treatment and referral for such services.

Direct Access for Chiropractic Care Services

Insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for In-Network covered Chiropractic Care services. There is no requirement to obtain an authorization of care from your Primary Care Physician (if you have selected one) for visits to the Participating Provider of your choice for Chiropractic Care.

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.

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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:

  (a) 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; **(b)** manifests before the individual reaches age nineteen; **(c)** is likely to continue indefinitely; and **(d)** 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.

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 or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services or training.

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

CERTIFICATE RIDER – Montana Residents

Rider Eligibility: Each Employee who is located in Montana

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

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

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

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Covered Expenses

Autism

Charges for diagnosis and treatment of autism spectrum disorders for a covered child 18 years of age or younger. Coverage must be provided to a child who is diagnosed with one of the following disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

- autistic disorder;
- Asperger's disorder; or
- pervasive developmental disorder not otherwise specified.

Coverage under this section includes:

- habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed Physician or licensed Psychologist, including but not limited to professional, counseling, and guidance services and treatment programs that are Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child;
- medications prescribed by a Physician licensed under Title 37, chapter 3;
- psychiatric or psychological care; and
- therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist licensed in this state.

Habilitative and rehabilitative care includes Medically Necessary interactive therapies derived from evidence-based research, including applied behavior analysis, which is also known as Lovaas therapy, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

Applied behavior analysis covered under this section must be provided by an individual who is licensed by the behavior analyst certification board or is certified by the Department of Public Health and Human Services as a family support specialist with an autism endorsement.

When treatment is expected to require continued services, Cigna may request that the treating Physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is Medically Necessary. The treatment plan must be based on evidence-based screening criteria. Cigna may ask that the treatment plan be updated every 6 months.

As used in this section, "Medically Necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a Physician or Psychologist licensed in this state and that will or is reasonably expected to:

- prevent the onset of an illness, condition, Injury, or disability;
- reduce or improve the physical, mental, or developmental effects of an illness, condition, Injury, or disability; or
- assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

Down Syndrome

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

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

Habilitative and rehabilitative care includes Medically Necessary interactive therapies derived from evidence-based research, including intensive intervention programs and early intensive behavioral intervention. Benefits provided may not be construed as limiting physical health benefits that are otherwise available to the covered child.

When treatment is expected to require continued services, the insurer may request that the treating Physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is Medically Necessary. The treatment plan must be based on evidence-based screening criteria. The insurer may ask that the treatment plan be updated every 6 months.

As used in this section, "Medically Necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a Physician licensed in this state and that will or is reasonably expected to reduce or improve the physical, mental, or developmental effects of Down syndrome; or assist in achieving maximum functional capacity in performing daily activities, taking into account

both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

Inborn Errors of Metabolism

Coverage for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist. Coverage must include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

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Mental Health and Substance Use Disorder Services

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

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

Inpatient Mental Health Services

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

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

Mental Health Residential Treatment Services are exchanged with Inpatient Mental Health Services at a rate of two days of Mental Health Residential Treatment being equal to one day of Inpatient Mental Health Treatment.

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

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

Outpatient Mental Health Services

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

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

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

Inpatient Substance Use Disorder Rehabilitation Services

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

Substance Use Disorder Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional

disturbances that are a result of subacute Substance Use Disorder conditions.

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

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

Outpatient Substance Use Disorder Rehabilitation Services

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

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

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

Substance Use Disorder Intensive Outpatient Therapy Program services are exchanged with Outpatient Substance Use Disorder services at a rate of one visit of Substance Use Disorder Intensive Outpatient Therapy being equal to one visit of Outpatient Substance Use Disorder Rehabilitation Services.

Substance Use Disorder Detoxification Services

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

Exclusions

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

- geriatric day care, occupational and recreational therapy for age related cognitive decline.
- special education, including but not limited to school tuition.
- counseling for educational reasons, IQ testing or other testing (including psychological testing on children requested by or for a school system).
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious training and counseling.
- cognitive rehabilitation.
- work-hardening programs.
- wilderness programs.
- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for borderline intellectual functioning.

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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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Covered Expenses

Mental Health and Substance Use Disorder Services

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

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

Inpatient Mental Health Services

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

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

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

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

Outpatient Mental Health Services

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

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

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

Inpatient Substance Use Disorder Rehabilitation Services

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

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

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

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

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

Outpatient Substance Use Disorder Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient

rehabilitation in an individual, or a Substance Use Disorder Intensive Outpatient Therapy Program.

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

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

Substance Use Disorder Detoxification Services

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

Exclusions

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

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

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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.

HC-POB108 01-17
ET

Definitions

Dependent

Dependents include:

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

- 26 years old, but less than 26, not married nor in a civil union partnership nor in a Domestic Partnership, enrolled in school as a full-time student and primarily supported by you.
- 26 or more years old, not married nor in a civil union partnership nor in a Domestic Partnership, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this plan, or while covered as a Dependent under a prior plan with no break in coverage.

  Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you; a child for whom you are responsible for pursuant to a court order; or your grandchild who is in your court ordered custody. It also includes a stepchild. If your civil union partner has a child, that child will also be included as a Dependent.

The term civil union means the legally recognized union of two eligible individuals of the same sex.

HC-DFS1477 01-20
ET

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

CERTIFICATE RIDER – New Mexico Residents

Rider Eligibility: Each Employee who is located in New Mexico

You will become insured on the date you become eligible, include 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 Mexico group insurance plans covering insureds located in New Mexico. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNMRDRV3

Definitions

Certification

The term Certification means a decision by Cigna that a Health Care Service requested by a Provider or Grievant has been reviewed and, based upon the information available, meets Cigna's requirements for coverage and Medical Necessity, and the requested Health Care Service is therefore approved.

HC-DFS476V2 05-12
ET

Covered Person

The term Covered Person means a policyholder, subscriber, enrollee, or other individual entitled to receive health care benefits provided by a Health Benefits Plan, and includes Medicaid recipients enrolled in a Health Care Insurer's Medicaid plan and individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act.

HC-DFS478 04-10
V2-ET

Culturally and Linguistically Appropriate Manner of Notice

The term Culturally and Linguistically Appropriate Manner of Notice means:

- A grievance related notice that meets the following requirements:
  - oral language services provided by Cigna (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;
  - a grievance related notice provided by Cigna, upon request, in any applicable non-English language;
  - included in the English versions of all grievance related notices provided by Cigna, a statement prominently

displayed in any applicable non-English language clearly indicating how to access the language services provided by Cigna; and

- for purposes of this definition, with respect to an address in any New Mexico county to which a grievance related notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language, as determined by the department of health and human services (HHS); the counties that meet this ten percent (10%) standard, as determined by HHS, are found at http://cciio.cms.gov/resources/factsheets/clas-data.html and any necessary changes to this list are posted by HHS annually.

HC-DFS609 05-12
ET

Grievant

The term Grievant means any of the following:

- A policyholder, subscriber, enrollee, or other individual, or that person's authorized representative or provider, acting on behalf of that person with that person's consent, entitled to receive health care benefits provided by Cigna;
- An individual, or that person's authorized representative, who may be entitled to receive health care benefits provided by Cigna;
- Medicaid recipients enrolled in a Cigna Medicaid plan, if Cigna offers such a plan.

If Cigna purchases or is authorized to purchase health care coverage pursuant to the New Mexico Health Care Purchasing Act, a Grievant includes individuals whose health insurance coverage is provided by such coverage.

HC-DFS477V2 05-12
ET

Health Benefits Plan

The term Health Benefit Plan means a health plan or a policy, contract, certificate or agreement offered or issued by a Health Care Insurer or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of Health Care Services; this includes a Traditional Fee-For-Service Health Benefits Plan.

HC-DFS479V2 05-12
ET

Health Care Insurer

The term Health Care Insurer means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan, fraternal benefit society, vision plan, or pre-paid dental plan.

HC-DFS480 04-10
V2-ET

Health Care Professional

The term Health Care Professional means a Physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide Health Care Services consistent with state law.

HC-DFS488 04-10
V2-ET

Health Care Services

The term Health Care Services means services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the Health Benefits Plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

HC-DFS481 04-10
V2-ET

Hearing Officer, Independent Co-Hearing Officer or ICO

The terms Hearing Officer, Independent Co-Hearing Officer or ICO mean a health care or other professional licensed to practice medicine or another profession who is willing to assist the superintendent as a Hearing Officer in understanding and analyzing Medical Necessity and coverage issues that arise in external review hearings.

HC-DFS482 04-10
V2-ET

Medical Necessity or Medically Necessary

The terms Medical Necessity or Medically Necessary mean Health Care Services determined by a Provider, in consultation with the Health Care Insurer, to be appropriate or

necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by the Health Care Insurer consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

HC-DFS483 04-10
V2-ET

Provider

The term Provider means a duly licensed Hospital or other licensed facility, Physician, or other Health Care Professional authorized to furnish Health Care Services within the scope of their license.

HC-DFS484 04-10
V2-ET

Rescission of Coverage

The term Rescission of Coverage means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

- the cancellation or discontinuance of coverage has only a prospective effect; or
- the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

HC-DFS608 05-12
ET

Termination of Coverage

The term Termination of Coverage means the cancellation or non-renewal of coverage provided by Cigna to a Grievant but does not include a voluntary termination by a Grievant or termination of a Health Benefits Plan that does not contain a renewal provision.

HC-DFS485V2 05-12
ET

Traditional Fee-For-Service Indemnity Benefit

The term Traditional Fee-For-Service Indemnity Benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage Grievants to utilize preferred Providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

HC-DFS486V2 05-12
ET

Uniform Standards

The term Uniform Standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by the Health Care Insurer consistent with the federal, national, and professional practice guidelines that are used by a Health Care Insurer in determining whether to certify or deny a requested Health Care Service.

HC-DFS487 04-10
V2-ET

Utilization Management Determinations

The term Utilization Management Determinations means the outcome, including Certification and adverse determination, of the review and evaluation of Health Care Services and settings for Medical Necessity, appropriateness, efficacy, and efficiency.

HC-DFS475 04-10
V2-ET

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

CERTIFICATE RIDER – North Carolina Residents

Rider Eligibility: Each Employee who is located in North Carolina

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

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

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

HC-ETNCRDR

Definitions

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

CERTIFICATE RIDER – North Dakota Residents

Rider Eligibility: Each Employee who is located in North Dakota

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

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

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

HC-ETNDRDR

Covered Expenses

Virtual Care

Virtual Physician Services - Telehealth

Includes charges for the delivery of medical and health-related services, consultations, and remote monitoring as medically appropriate services provided via Telehealth.

- Telehealth means the use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site, to deliver health services to an originating site and is delivered over a secure connection that complies with state and federal requirements:
  - includes the use of electronic media for consultation relating to the diagnosis or treatment of a patient in real time or through the use of store-and-forward technology.
  - does not include the use of audio-only telephone, electronic mail, or facsimile transmissions.

HC-COV1247 01-22
ET1

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

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

  - Require coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
  - Require coverage for experimental drugs not approved for any indication by the FDA;
  - Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the FDA;
  - Require reimbursement or coverage for any drug not included in the drug formulary or list of covered drugs specified in the policy;
  - Prohibit Cigna from limiting or excluding coverage of a drug, provided that the decision to limit or exclude coverage of the drug is not based primarily on the coverage of drugs described in this provision.

Virtual Care - Medical

Virtual Physician Services/Telemedicine

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

- charges made for Medically Necessary Synchronous Teledentistry.

HC-COV1242 01-23
ET3

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered Under the Medical Plan

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

HC-EXC492 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.

HC-TRM140 12-18
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 – Oregon Residents

Rider Eligibility: Each Employee who is located in Oregon

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

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

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

HC-ORMEPO-04-11 HC-ETORRDR

Certification Requirements

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Any PAC determination will be binding on Cigna for:

- the lesser of: 5 business days; or in the event your coverage will terminate sooner than 5 business days, the period your coverage remains in effect, provided that when PAC is authorized:
  - Cigna has specific knowledge that your coverage will terminate sooner than 5 business days; and
  - the termination date is specified in the PAC; or
- the time period your coverage remains in effect, subject to a maximum of 30 calendar days.

For purposes of counting days, day 1 occurs on the first business or calendar day, as applicable, following the day on which Cigna issues a PAC.

Cigna will respond to a PAC request for a non-emergency admission within two business days of the date of the request. Qualified health care personnel will be available for same-day telephone responses to CSR inquiries.

HC-PAC4 11-14
V2-ET

Mental Health and Substance Use Disorder Services

Charges for Medically Necessary medical services, including rehabilitation services, for a dependent child who has been diagnosed with a pervasive developmental disorder are covered. “Pervasive developmental disorder” means a neurological condition that includes Asperger’s syndrome, autism, developmental delay, developmental disability or intellectual disability. “Rehabilitation services” means physical therapy, occupational therapy or speech therapy services to restore or improve function.

HC-COV829 01-23
ET

Definitions

Dependent

The term child means a child born to you or a child legally adopted by you including that child from the date of placement. Coverage for such child will include the necessary care and treatment of medical conditions existing prior to the date of placement including medically diagnosed congenital defects or birth abnormalities. It also includes a grandchild

who is considered your Dependent for federal income tax purposes or a stepchild.

HC-DFS1682 01-23
ET1

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

CERTIFICATE RIDER – Pennsylvania Residents

Rider Eligibility: Each Employee who is located in Pennsylvania

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

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

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

HC-ETPARDR

Covered Expenses

- charges made for or in connection with mammograms, including digital breast tomosynthesis, for breast cancer screening and diagnosis, not to exceed: a baseline mammogram annually for women age 40 and over; and a mammogram upon a Physician's recommendation for women under age 40.
- 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-COV1223 01-22
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

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 – South Dakota Residents

Rider Eligibility: Each Employee who is located in South Dakota

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

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

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

HC-ETSDRDR

Certification Requirements

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents, and in the determination notices.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; 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 claim; 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; information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving Urgent Care, a description of the expedited review process applicable to such claim; and in the case of rescission, a clear identification of the alleged fraudulent practice or omission or the intentional misrepresentation of material fact, and an explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact, and the effective date of the rescission.

HC-PAC102 01-20
ET

Covered Expenses

Virtual Physician Services

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

HC-COV1250 01-22
ET1

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.

HC-EXC497 01-22
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-COV1229 01-23
ET1

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-COV1348 01-24
ET1

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

CERTIFICATE RIDER – Utah Residents

Rider Eligibility: Each Employee who is located in Utah

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

HC-ETUTRDR

Eligibility - Effective Date

Exception for Newborns

Any Dependent child born or adopted (and placed with you within 30 days of birth) while you are insured will become insured on the date of his birth if you elect Dependent Insurance, according to the following:

If enrolling the adopted or newborn child changes the premium no later than 31 days after his birth.

If additional premium is not required for the newborn or adopted child to receive coverage, the certificate holder must enroll a newly born or adopted child no later than 30 days after the first notification of denial of a claim for services for that child.

If you do not elect to insure your newborn or adopted child within such time, coverage for that child will end on the 31st day after birth. No benefits for expenses incurred beyond the 31st day will be payable.

HC-ELG265 01-19

ET

Dependent

A child also includes a legally adopted child, including that child from the date of placement for adoption. Coverage for an adopted child will begin from:

- the moment of birth, if adoption occurs within 30 days of the child's birth; or
- the date of placement, if placement for adoption occurs 30 days or more after the child's birth.

This coverage requirement ends if the child is removed from placement prior to the child being legally adopted.

"Placement For Adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

When an administrative or court order exists, coverage will be provided by Cigna without regard to the enrollment period, dependency, residence or service area. You, your lawful spouse, state agency, or child support enforcement program may enroll the child.

A child may not be denied coverage on the sole basis that the child does not reside with you or because the child is solely dependent on a former spouse rather than you.

HC-DFS1691 01-22

ET1

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.

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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.

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Definitions

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability.

    Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. The plan may require proof not more frequently than annually after the two year period following the child's attainment of the limiting age.

The term child means a child born to you or a child legally adopted by you including a child for whom you assume legal obligation for total or partial support, in anticipation of adoption, but with no requirement that the adoption be final. It also includes a stepchild. If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

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

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

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