STRYKER CORPORATION

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2024

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

Printed in U.S.A.

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Cigna

CIGNA HEALTH AND LIFE INSURANCE COMPANY a Cigna COMPANY (called Cigna)
CERTIFICATE RIDER

Policyholder: Wilmington Trust National Association
Group**:** Stryker Corporation
Rider Eligibility: Each Member as noted within this certificate rider
Policy No.: 03059A
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 Delaware:

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 Members residing in that state. The state for which the rider is applicable is identified at the beginning of each state specific rider.

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

(a) Benefit plans made available to you and/or your Dependents by the Group;
(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-ETRDRV4 01-20

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

Important Notices

Accessing Health Care

To contact the Department of Insurance, for complaints regarding your ability to access health care in a timely manner, write or call:

Consumer Affairs Division
California Department of Insurance
Ronald Reagan Building
300 South Spring Street
Los Angeles, CA 90013

Calling within California: 1-800-927-4357

Los Angeles Area and Outside California: 1-213-897-8921

The Department of Insurance should be contacted only after discussions with the insurer have failed to produce a satisfactory resolution to the problem.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

Participating Providers

Copayment, Deductible, and Coinsurance options reflect the amount the covered person will pay for in-network and out-of-network benefits. In-network benefits require use of Participating Providers or facilities in the Service Area. Cigna recommends use of Participating Providers and facilities, as member out-of-pocket costs could be lower than when using non-Participating Providers.

Service Area

The term Service Area means the area in which Cigna has a Participating Provider network. Cigna's national network of Participating Providers is within the United States. Cigna's toll-free care line personnel can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may obtain a listing of Participating Providers by calling the number on your I.D. card. A listing of Participating Providers can also be found at www.cignaenvoy.com.

Emergency Services

Benefits for services and supplies received outside the Service Area are covered only for medical emergencies and other urgent situations where treatment could not have been reasonably delayed until the insured person was able to return to the United States.

To contact the Department of Insurance, write or call:

Consumer Affairs Division
California Department of Insurance
Ronald Reagan Building
300 South Spring Street
Los Angeles, CA 90013

Calling within California: 1-800-927-4357

Los Angeles Area and Outside California: 1-213-897-8921

The Department of Insurance should be contacted only after discussions with the insurer have failed to produce a satisfactory resolution to the problem.

Your Rights Under HIPAA If You Lose Group Coverage

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

- you have 18 or more months of creditable coverage without a break of 63 days or more between any of the periods of

creditable coverage or since your most recent coverage was terminated;

- your most recent creditable coverage was a group, government or church plan that provided hospital, medical or surgical benefits. (COBRA and Cal-COBRA are considered group coverage);
- you were not terminated from your most recent creditable coverage due to nonpayment of premiums or fraud;
- you are not eligible for coverage under a group health plan, Medicare, or Medicaid (Medi-Cal);
- you have no other health insurance coverage; and
- you have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA.

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

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

Important Notices

Important Information About Free Language Assistance

No Cost Language Services for customers who live in California and customers who live outside of California who are covered under a policy issued in California. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-800-441-2668 for Cigna. For more help, call the CA Dept. of Insurance at 1-800-927-4357. **English**

Servicios de idioma sin costo para asegurados que viven en California y para asegurados que viven fuera de California y que están cubiertos por una póliza emitida en California. Puede obtener un intérprete. Puede hacer que le lean los documentos en español y que le envíen algunos de ellos en ese idioma. Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación o al 1-800-441-2668 para servicios médicos/dentales de Cigna o al 1-866-421-8629 para servicios de salud mental/farmacodependencia de Cigna Behavioral Health. Para obtener ayuda adicional, llame al Departamento de Seguros de CA al 1-800-927-4357. **Spanish**

居住在加州境內的被保人和居住在加州境外但受到加州境內核發保單承保的被保人可取得免費語言服務。**您可取得口譯員服務。**我們可以用中文將文件讀給您聽，並將部分備有中文版的文件寄送給您。欲取得協助，請撥打您會員卡上所列示的電話號碼，或致電 1-800-441-2668 與 Cigna 醫療 / 牙科聯絡，或撥打 1-866-421-8629 聯繫 Cigna Behavioral Health 精神健康 /
物質濫用。欲取得其他協助，請致電 1-888-466-2219 與 HMO 協助中心聯絡，或非 HMO 計畫 (例如：PPO) 請致電 1-800-927-4357 與加州保險部聯絡。**Chinese**

خدمات لغوية بدون تكلفة للعملاء المقيمين في ولاية كاليفورنيا والعملاء المقيمين خارج ولاية كاليفورنيا الذين تشملهم سياسة تأميين صاارر فأي ولاياأة

كاليفورنيا. يُمكنك الاستعانة بمترجم. يمكنك طلب قراء الوثائق لك وإرسال بعض ينها إليك بلغتك. للحصول على المساعد ، اتصل بنا على الرقم المبين

على بطاقة عضويتك أو على الرقم 1-800-244-6244 لخديات الطبية / صحة الأسنان أو على الرقم 1-866-421-8629 Cigna للصأحة السألوكية والنفسأأية / إسأاء اسأتخدام Cigna لخديات المأأوار المخأدر . للحصأول علاأى المعيأد يأن المسأأاعد ، اتصأل للمسأاعد علأى الأأرقم HMO إيأا بمركأأع

اتصل ،) PPO يثل) HMO أو للبرايج الأخرى غير 1-888-466-2219 . بإرار التميين لولاية كاليفورنيا على الرقم 1-800-927-4357
Arabic

캘리포니아 거주 고객 및 캘리포니아에서 발행된 보험으로 보장을 받는 캘리포니아 이외 지역 거주 고객님들을 위한 **무료 언어 지원 서비스**. 귀하는 통역 서비스를 받으실 수 있습니다. 한국어로 서류를 낭독해주는 서비스를 받으실 수 있으며 한국어로 번역된 서류를 받아보실 수도 있습니다. 도움이 필요하신 분은 본인의 ID 카드상에 기재된 안내번호 혹은 Cigna 의료/치과 안내번호(1-800-441-2668번), 혹은 Cigna Behavioral Health 정신 건강/약물 남용 안내번호(1-866-421-2219번)으로 연락해주십시오. 더 많은 도움이 필요하신 분은 HMO 헬프 센터(HMO Help Center), 안내번호 1-888-466-2219번으로 문의하시거나 비-HMO 플랜(예: PPO)에 해당하시는 분은 캘리포니아주 보험국(CA Dept. of Insurance), 안내번호 1-800-927-4357번으로 연락해주십시오. **Korean**

Walang Gastos na Mga Serbisyo sa Wika para sa mga customer na nakatira sa California at mga customer na

nakatira sa labas ng California na sakop ng isang polisiyang inisyu sa California. Makakakuha ka ng interpreter. Maaari mong ipabasa para sa iyo ang mga dokumento at maaaring ipadala sa iyo ang ilan sa iyong wika. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-800-441-2668 para sa medikal/dental ng Cigna o sa 1-866-421-8629 para sa kalusugang pangkaisipan/pag-abuso sa droga ng Cigna Behavioral Health. Para sa karagdagang tulong, tumawag sa HMO Help Center sa 1-888-466-2219 o para sa mga planong Hindi HMO (hal. PPO) tawagan ang CA Dept. of Insurance sa 1-800-927-4357. **Tagalog**

Dịch vụ trợ giúp ngôn ngữ miễn phí cho khách hàng sinh sống trong tiểu bang California và khách hàng sống

ngoài California được đài thọ qua một hợp đồng bảo hiểm y tế ký kết tại California. Quý vị có thể được cấp thông

dịch viên. Quý vị có thể được có người đọc văn bản cho quý vị hoặc được nhận tài liệu, văn bản bằng ngôn ngữ của

quý vị. Để được giúp đỡ, vui lòng gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên (ID) của quý vị hoặc gọi

cho chương trình bảo hiểm y tế/nha khoa Cigna tại số 1-800-441-2668, hoặc gọi số 1-866-421-8629 cho chương

trình chăm sóc sức khỏe tâm thần/lạm dụng chất gây nghiện thuộc Chương trình Sức khỏe Hành vi của Cigna. Để

được giúp đỡ thêm, vui lòng gọi Trung tâm Trợ giúp HMO tại 1-888-466-2219 hoặc gọi Bộ Bảo hiểm California tại

số 1-800-927-4357 cho các vấn đề thuộc các chương trình bảo hiểm không thuộc loại HMO (như các chương trình

PPO). **Vietnamese**

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ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਉਹਨਾਂ ਗਾਹਕਾਂ ਲਈ ਹਨ ਜੋ ਕੈਲੀਫ਼ੋਰਨੀਆ ਵ ਿੱਚ ਰਵਹੀਂ ਦੇ ਹਨ ਅਤੇ ਉਹਨਾਂ ਗਾਹਕਾਂ ਲਈ ਜੋ ਕੈਲੀਫ਼ੋਰਨੀਆ ਤੋਂ ਬਾਹਰ

ਰਵਹੀਂਦੇ ਹਨ ਅਤੇ ਕਲੈ ੀਫ਼ਰੋ ਨੀਆ ਵ ਿੱਚ ਜਾਰੀ ਕੀਤੀ ਗਈ ਪਾਵਲਸੀ ਦੇ ਅਧੀਨ ਕ ਰਡ ਹਨ। ਤੁਹਾਨੀਂ ਦਭੁ ਾਸ਼ੀਆ ਵਲਿ ਸਕਦਾ ਹੈ। ਤੁਹਾਨੀਂ

ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵ ਿੱਚ ਦਸਤਾ ੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾਏ ਜਾ ਸਕਦੇ ਹਨ ਅਤੇ ਕੁਝ ਤੁਹਾਨੀਂ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਦਿਦ ਲਈ ਸਾਨੀਂ ਆਪਣੇ ਆਈ.ਡੀ.

ਕਾਰਡ ਉੱਤੇ ਵਦੀੱ ਤੇ ਗਏ ਨੀਂ ਬਰ ਤੇ ਜਾਂ Cigna ਿੈਡੀਕਲ/ਡੈਂਟਲ ਲਈ 1-800-441-2668 ਤੇ ਜਾਂ Cigna ਵ ਹਾਰਕ ਵਸਹਤ ਾਿਨਵਸਕ

ਵਸਹਤ/ਪਦਾਰਥਾਂ ਦੇ ਦੁਰਉਪਯੋਗ ਲਈ 1-866-421-8629 ਤੇ ਫੋਨ ਕਰੋ। ਹੋਰ ਦਿਦ ਲਈ, ਜਾਂ ਤਾਂ HMO ਦਿਦ ਕੇਂਦਰ ਨੀਂ

1-888-466-2219 ਤੇ ਫੋਨ ਕਰੋ ਜਾਂ ਗੈਰ HMO ਯੋਜਨਾ ਾਂ (ਉਦਾਹਰਣ ਲਈ PPO) ਲਈ CA ਦੇ ਬੀਿਾ ਵ ਭਾਗ (CA Dept.

of Insurance) ਨੀਂ 1-800-927-4357 ਤੇ ਫੋਨ ਕਰੋ। **Punjabi**

خدمات مجانی مربوط به زبان برای یشتریانی که رر کالیفرنیا زندگی یی کنند و یشتریانی که رر خارج کالیفرنیا زندگی کرره و بر اساس بیمه نایه

ای که رر کالیفرنیا صارر شده تحت پوشش هستند. یی توانید از خدیات یک یترجم شفاهی برخوررار شوید. یی توانید بگوئید که یدارک به زبان شما

برایتان قرائت شوند و برخی از آنها به زبان شما برایتان ارسال شوند. برای رریافت کمک، با یا از طریق شماره تلفنی که روی کارت شناسائی شما

برای طرح Cigna 1 برای -421-866- و یا به شماره 1 8629 پعشکی/رندانپعشکی -800-244- قید شده است تماس بگیرید و یا به شماره 6224

تلفن کنید. برای رریافت کمک بیشتر، به یرکع کمک HMO به برنایه بهداشت روانی/سوء استفاره از یوار یخدر طرح Cigna بهداشت رفتاری

تلفن کنید. -800-927- به اراره بیمه کالیفرنیا به شماره 1 4357 و یا برای طرح های غیر -866-466 1 HMO (برای یثال PPO(شماره 2219

Persian

無料の言語サービス。カリフォルニア州にお住まいのお客様、および、カリフォルニア州外にお住まい

で、カリフォルニア州において発行された保険のお客様が対象。通訳がご利用でき、書類を日本語で

お読みします。また、書類によっては日本語版をお届けできるものもあります。サービスをご希望の方

は、IDカードに記載の電話番号、またはCigna医療・歯科サービス担当：1-800-441-2668、またはCigna

Behavioral
Health（メンタルヘルス・薬物乱用）サービス担当：1-866-421-8629までご連絡ください。そ

の他のお問い合わせは、HMO Help Center：1-888-466-2219、またはNon-HMOプラン（例：PPO「優先医

療給付機構」）については、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。**Japanese**

Бесплатные услуги перевода для клиентов, проживающих на территории штата Калифорния, а также для

тех клиентов, которые проживают за его пределами и имеют страховой полис, выданный в штате

Калифорния. Вы имеете право воспользоваться услугами устного переводчика. Вам могут прочесть ваши

документы, а также выслать перевод некоторых из них на вашем языке. Для получения помощи, позвоните

нам по телефону, указанному в вашей Идентификационной карте, по вопросам медицинского и

стоматологического обслуживания, предоставляемого компанией Cigna, позвоните по телефону

1-800-441-2668, по вопросам связанным с психическим здоровьем/злоупотреблением алкоголем или

наркотиками обращайтесь по телефону 1-866-421-8629 в программу Cigna Behavioral Health. Для получения

дополнительной помощи обращайтесь либо в Центр поддержки HMO по телефону 1-888-466-2219 либо

обращайтесь в Министерство страхования штата Калифорния (CA Dept. of Insurance) по телефону

1-800-927-4357 для получения информации в отношении не HMO планов (например PPO). **Russian**

Անվճար Լեզվական Ծառայություններ անդամների համար, ովքեր բնակվում են Կալիֆորնիայում և

անդամների համար, ովքեր բնակվում են Կալիֆորնիայից դուրս բայց ապահովագրված են

Կալիֆորնիայում տրված ապահովագրությամբ: Դուք կարող եք թարգմանիչ ձեռք բերել: Դուք կարող

եք փաստաթղթերը ձեր լեզվով ընթերցել տալ ձեզ համար և նրանց մի մասը ստանալ ձեր լեզվով:

Օգնության համար, զանգահարեք մեզ ձեր ինքնության (ID) տոմսի վրա նշված համարով կամ՝

1-800-244-6244, Cigna-ի բժշկական/ատամնաբուժական ծրագրի համար կամ՝ 1-866-421-8629 Cigna

Վարվեցողական Առողջապահության հոգեկան առողջության/թմրամոլության համար: Լրացուցիչ

օգնության համար զանգահարեք կա՛մ HMO-ի Օգնության կենտրոն 1-888-466-2219 համարով կամ՝

Ոչ-HMO ծրագրերի համար (օրինակ՝ PPO) զանգահարեք Կալիֆորնիայի Ապահովագրության

Բաժանմունք 1-800-927-4357 համարով: **Armenian**

Cov Kev Pab Txhais Lus Uas Tsis Tau Them Nqi rau cov qhua uas nyob hauv xeev California thiab cov qhua uas

nyob tawm Xeev California uas tau muaj kev pov fwm los ntawm California. Koj yeej muaj tau tus neeg txhais lus.

Koj hais tau kom muab cov ntawv nyeem rau koj mloog thiab kom muab qee cov ntaub ntawv txhais ua koj hom lus

xa rau. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-441-2668 rau

Cigna chaw pab them nqi kho mob/kho hniav los sis 1-866-421-8629 rau Cigna Chaw pab them nqi kho Kev Coj

Cuj Pwm kev puas hlwb/kev quav tshuaj yeeb dej caw. Yog xav tau kev pab ntxiv, hu rau HMO Qhov Chaw Muab

Kev Pab ntawm tus xov tooj 1-888-466-2219 los sis rau cov chaw pab them nqi kho mob uas Tsis Koom HMO (piv

txwv li yog PPO) hu rau CA Lub Tuam Tsev Tswj Xyuas Txog Kev Tuav Pov Hwm ntawm 1-800-927-4357.

HC-SPP46 06-18

HC-IMP241 ET

Eligibility - Effective Date

Employee Insurance

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you are eligible for coverage through a guarantee association and you elect the insurance more than 60 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you are a Dependent who has lost or will lose coverage under Medi-Cal, the Healthy Families Program (HFP), or the Access for Infants and Mothers Program (AIM) and you elect the insurance more than 60 days after you become eligible and you declined coverage during your initial enrollment period by signing a Declination of Medical Coverage form, provided by your Employer; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns and Adopted Children

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

HC-ELG219 01-19
V1 ET

The Schedule

If you are enrolled in a medical plan with In and Out-of-Network features, **The Schedule** shown in your medical certificate is amended to include the following paragraph:

If you receive a covered service from a participating Hospital or other participating facility that is provided by a non-Participating Provider you will be required to pay the non-Participating Provider the same cost share required by a Participating Provider. At the time that Cigna reimburses the non-Participating Provider for the services provided, Cigna will inform you of any In-Network cost-sharing amount you may owe. Any In-Network cost sharing will be applied toward any In-Network Deductible and Out-of-Pocket maximum.

SCHED-ET1

Certification Requirements

For You and Your Dependents

Continuity of Care

Upon your request, Cigna shall provide or arrange for the completion of covered services from a terminated Participating Provider or a non-Participating Provider if you have one of the following conditions and were receiving services from the terminated Participating Provider or non-Participating Provider at the time of the contract termination or at the time you became eligible under the Policy. You will qualify to receive continued services for the following conditions and specified time periods:

- **an acute condition**. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, Injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
- **a serious chronic condition**. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Cigna in consultation with you and the terminated Participating Provider or non-Participating Provider and consistent with good professional practice. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered person.
- **a pregnancy.** A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
- **a terminal illness.** A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a terminal illness.
- The care of a newborn child between birth and age 36 months. Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered person.
- performance of a surgery or other procedure that is authorized by Cigna as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered person.

Provider's Responsibility. In order for a terminated Participating Provider or non-Participating Provider to continue caring for an insured, the terminated Participating Provider or non-Participating Provider must comply with Cigna's contractual and credentialing requirements and must meet Cigna's standards for utilization review and quality assurance. The terminated Participating Provider or non-Participating Provider must also agree to a mutually acceptable rate of payment. If these conditions are not met, Cigna is not required to arrange for continuity of care.

Cigna is not obligated to arrange for continuity of care with a terminated Participating Provider or non-Participating Provider who has been terminated for medical disciplinary reasons or who has committed fraud or other criminal activities.

Arranging for Continuity of Care. If the insured meets the necessary requirements for continuity of care as described herein, and would like to continue his/her care with a terminated Participating Provider or non-Participating Provider, the insured should call the Member Services Department at the number shown on the I.D. card to make a formal request for continuity of care.

This information will be reviewed by Cigna to determine if the insured's medical condition and the terminated Participating Provider or non-Participating Provider's status qualifies for continuity of care.

The insured will be notified if continuity of care arrangements can be made with the insured's current terminated Participating Provider or non-Participating Provider and will receive information relating to the extent and length of care that can be provided. Cigna will make every effort to expedite the review and inform the insured of the continuity of care decision as soon as possible. If the insured does not meet the requirements for continuity of care or if the terminated Participating Provider or non-Participating Provider refuses to render care or has been determined unacceptable for quality or contractual reasons, Cigna will work with the insured to accomplish a timely transition to another qualified Participating Provider.

To make a request for continuity of care, please call the number on your I.D. card as early as possible so the review process can begin and your treatment can continue.

HC-PAC86 01-19
ET

Covered Expenses

- charges made for or in connection with mammograms for breast cancer screenings or diagnostic purposes including, but not limited to: a baseline mammogram for women age 35, but less than 40; a mammogram for women age 40, but less than 50, every two years or more, if Medically Necessary and if recommended by a Physician, nurse practitioner or a nurse midwife; and a mammogram every year for women age 50 and over.
- charges made for an annual Papanicolaou laboratory screening test.
- charges for the screening and diagnosis of prostate cancer, including, but not limited to, Medically Necessary prostate-specific antigen testing and digital rectal examinations.
- charges made for services related to the diagnosis, treatment, and management of osteoporosis. Covered services include, but are not limited to, all FDA approved technologies, including bone mass measurement technologies as deemed Medically Necessary.
- charges made for expenses incurred at any of the Approximate Age Intervals shown below for a Dependent child who is age 16 or less, for charges made for Child Preventive Care consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:
  - physical examinations;
  - appropriate immunizations; and
  - laboratory tests in connection with physical examinations.

  excluding any charges for:
  - more than one visit to one provider for Child Preventive Care Services at each of the Appropriate Age Intervals up to a total of 18 visits for each Dependent child;
  - services for which benefits are otherwise provided under this Covered Expenses section; or
  - services for which benefits are not payable according to the "Expenses Not Covered" section.

  Approximate Age Intervals are: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years and 16 years.
- HIV testing regardless of whether testing is related to the patient's primary diagnosis.
- charges made for telehealth services. Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the Provider for telehealth is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes:
  - Synchronous Interactions: Synchronous Interaction means a real-time interaction between a patient and a Health Care Provider for telehealth located at a distant site; and
  - Asynchronous Store and Forward transfers: Asynchronous Store and Forward means the transmission of a patient's medical information from an originating site to the health care provider for telehealth at a distant site without the presence of the patient.

Originating site means a site where a patient is located at the time health care services are provided via telecommunications system or where the Asynchronous Store and Forward service originates.

Distant site means a site where a Health Care Provider for telehealth who provides health care services is located while providing these services via a telecommunications system.

- coverage for the testing and treatment of PKU. This includes formulas and special food products that are part of

a diet prescribed by a Physician and managed by a health care professional in consultation with a Physician specializing in the treatment of metabolic diseases. The diet must be deemed Medically Necessary to avoid the development of serious mental or physical disabilities or to promote normal development or function resulting from PKU.

Formula means an enteral product used in the home and prescribed by a Physician, nurse practitioner, or registered dietician for Medically Necessary treatment of PKU. Special food products are those that are prescribed by a Physician or Nurse practitioner for the treatment of PKU and are consistent with the recommendations and best practices of qualified health professionals with expertise in treatment and care of PKU. It does not include a food that is naturally low in protein. It may include a food product that is specially formulated to have less than one gram of protein per serving and is used instead of normal food products used by the general population, such as grocery store foods.

- charges made for Medically Necessary treatment of Severe Mental Illness for covered persons of any age, and Serious Emotional Disturbances of a Dependent Child under 18 years old.
- charges made for prosthetic appliances, including devices to restore a method of speaking following a laryngectomy, other than electronic voice-producing machines;
- charges for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following a cesarean section for both mother and newborn. The mother and/or newborn may be discharged earlier if the Physician consults with the mother. If discharged early, there will be at least one follow-up visit within 48 hours of discharge. Follow-up care may be in the mother's home, in the Physician's office, or in a licensed facility. An additional length of stay beyond the 48/96 hours will be covered if Medically Necessary.

The following describes coverage provided for the treatment of diabetes:

- charges for the following Medically Necessary equipment for the management and treatment of insulin-using diabetes, noninsulin-using diabetes, and gestational diabetes: blood glucose monitors; blood glucose monitors designed to assist the visually impaired; insulin pumps and all related necessary supplies; podiatric devices to prevent or treat diabetes-related complications; and visual aids (not including eyewear) to assist the visually impaired with proper dosing of insulin.
- charges for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to allow a covered person to properly use the equipment, supplies, and medications listed previously, and any additional diabetes outpatient self-management training, education, and medical nutrition therapy prescribed by or directed by a Physician.
- charges for insulin, insulin syringes, Prescriptive medications for the treatment of diabetes, lancets and lancet puncture devices, blood glucose testing strips, ketone urine testing strips, pen delivery systems for the administration of insulin and Glucagon.
- charges for cancer screening tests that are based on generally accepted medical guidelines or scientific evidence.
- charges for prenatal testing resulting from participation in the Expanded Alpha Feto Protein program administered by the State Department of Health Services. No Cost share
- charges for general anesthesia and associated facility charges for dental procedures rendered in a Hospital or Ambulatory Surgical Facility for: a child under the age of 7; an individual who is developmentally disabled; or an individual whose health is compromised and general anesthesia is Medically Necessary.
- charges for a Hospital stay resulting from a mastectomy and/or lymph node dissection for a period of time determined by a Physician in consultation with the patient.
- charges made for a drug that has been prescribed for purposes other than those approved by the FDA will be covered if:
  - the drug is otherwise approved by the FDA;
  - the drug is used to treat a life-threatening condition or, a chronic and seriously debilitating condition and the drug is Medically Necessary to treat that condition;
  - the drug has been recognized for the treatment prescribed by any of the following: the American Hospital Formulary Service Drug Information, one of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard’s Clinical Pharmacology; The National Comprehensive Cancer Network Drug and Biologics compendium; The Thomson Micromedix Drug Dex; or two articles from major peer reviewed medical journals that present data supporting the proposed use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.
- charges made for surgical or non-surgical treatment of Temporomandibular Joint Dysfunction.

Clinical Trials

Charges made for a covered person diagnosed with cancer and accepted into a phase I through phase IV clinical trial for cancer if the treating Physician recommends participation

in clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the covered person. The clinical trial must meet the following requirements:

- the trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.
- the treatment provided in a clinical trial must either be approved by the National Institutes of Health, the Federal Food and Drug Administration, the U.S. Department of Defense, or the U.S. Veterans' Administration, or Involve a drug that is exempt under federal regulations from a new drug application.

Routine Patient care costs associated with the provision of health care services, including drugs, items, devices and services that would otherwise be covered by Cigna if they were not provided in connection with a clinical trial, including the following:

- services typically provided absent a clinical trial.
- services required solely for the provision of the investigational drug, item, device or service.
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service.
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service.
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Coverage is provided by participating hospitals and physicians located in California unless clinical trial protocol is unavailable.

Autism

Spectrum Disorder

Covered expenses are professional services and treatment programs, including applied behavior analysis (ABA), and evidence-based behavior intervention programs that develop or restore to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism provided that:

- The treatment is prescribed by a licensed Physician or is developed by a licensed psychologist.
- The treatment is provided under a treatment plan prescribed by a qualified autism service provider.
- The treatment plan has measurable goals over a specific time-line that is developed and approved by the qualified autism service provider for the specific patient being treated.
- The treatment plan is not used for purposes of providing/reimbursing respite care, day care or educational services and is not used to reimburse a parent for participating in the treatment program.

HC-COV727 08-18
ET

Home Health Services

- charges made for Home Health Services when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility.

  Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

  Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

HC-COV76 04-10
V1-ET

Orthoses and Orthotic Devices

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

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

The following are specifically excluded orthoses and orthotic devices:

- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

HC-COV9 02-14
V8-ET

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function; or 2) to create normal appearance, to the extent possible. Reconstructive Surgery also includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate means a condition that may include cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

HC-COV728 08-18
ET

Medical Pharmaceuticals

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

HC-COV553 10-16
ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

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

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed, and is recognized as safe and effective for the treatment of cancer in any of the standard reference compendia: (A) The American Hospital Formulary Service's Drug Information, (B) One of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i). The Elsevier Gold Standard's Clinical Pharmacology; (ii) The National Comprehensive Cancer Network Drug and Biologics compendium; (iii) The Thomson Micromedix DrugDex, (C) two articles from major peer-reviewed medical journals that that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance. Cosmetic surgery and therapy does not include gender reassignment services.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, and dentures.
- dental implants for any condition unless services are an integral part of reconstructive surgery for Cleft Palate.

HC-EXC333 01-19 ET

Payment of Benefits

Assignment and Payment of Benefits

Ambulance benefits will be paid directly to the provider of the ambulance service.

HC-POB143 01-19 ET

Termination of Insurance

Continuation of Coverage Under Cal-COBRA

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Employer groups with 20 or more Employees

You and your Dependents may elect to continue health coverage after you have exhausted continuation coverage under COBRA. Cal-COBRA is not applicable to Domestic Partners and their Dependents or to stepchildren. This continuation coverage (Cal-COBRA) will be provided for up to 36 months from the date your COBRA continuation coverage began, if you are entitled to less than 36 months of continuation coverage under COBRA.

Employer groups with less than 20 Employees

This Continuation applies to you and your Dependents if your Employer is subject to Cal-COBRA law. Domestic Partners and stepchildren will not be eligible for Cal-COBRA independent from the Employee. Cal-COBRA law applies to any small Employer that employed 2 to 19 eligible Employees on at least 50 percent of its working days during the preceding calendar year, or, if the Employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible Employees on at least 50 percent of its working days during the preceding calendar quarter. This continuation coverage will be provided for up to 36 months from the date of the Qualifying Event.

Notice Requirements

Under the requirements of Cal-COBRA, an Employer must give notice to its Employees and Dependents the right to continue their group health care benefits. A person who would otherwise lose coverage as a result of a Qualifying Event is generally entitled to continue the same benefits that were in effect the day before the date of the qualifying event. Coverage may be continued under Cal-COBRA only if the required premiums are paid when due and will be subject to future plan changes.

Qualifying Events for Continuation of Cal-COBRA Coverage

A **Qualifying Event** is any of the following:

- termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked so as to render the Employee ineligible for coverage;
- death of the Employee;
- divorce or legal separation of the Employee from his or her spouse;
- with respect to Dependents only, the loss of coverage due to the Employee becoming entitled to Medicare;
- a Dependent child ceasing to qualify as an eligible Dependent under the plan.

Notification Requirements

The Employer will notify Cigna (or an administrator acting on Cigna's behalf) in writing, of termination or reduction of hours with respect to any Employee who is employed by the Employer, within 30 days of the date of the qualifying event. You may be disqualified from receiving Cal-COBRA continuation coverage if your Employer does not provide the required written notification to Cigna (or an administrator acting on Cigna's behalf).

The Employer shall also notify Cigna (or an administrator acting on Cigna's behalf) in writing, within 30 days of the date, when the Employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1161 et seq., or when the Employer becomes subject to federal COBRA requirements.

To be eligible for continuation coverage, for one of the Qualifying Event(s) you or your Dependent must notify Cigna (or an administrator acting on Cigna's behalf) in writing of such Qualifying Event within 60 days after the event occurs.

If you or your Dependent do not notify Cigna (or an administrator acting on Cigna's behalf) in writing within 60 days of the Qualifying Event(s), you will be disqualified from receiving Cal-COBRA continuation coverage.

Once notified of the Qualifying Event, Cigna (or an administrator acting on Cigna's behalf) will send you or your Dependent the necessary benefit information, premium information, enrollment form and notice requirements within 14 days after receiving notification of the Qualifying Event from the Employer, you or your Dependent. The information shall be sent to the qualified beneficiary's last known address. Notice of the right to continue coverage to your spouse will be deemed notice to any Dependent child residing with your spouse.

Formal Election

To continue group coverage under Cal-COBRA you must make a formal election by submitting a written request to Cigna (or an administrator acting on Cigna's behalf) at: Cigna, Attn: State Continuation Unit, P.O. Box 2010, Concord, NH 03302. For questions, call 1-800-315-6011.

The written request must be delivered by first-class mail, certified mail or other reliable means of delivery within 60 days of the later of the following dates:

- the date of the Qualifying Event;
- cathe date the qualified beneficiary receives notice of the ability to continue group coverage as provided above; or
- the date coverage under the Employer's health plan terminates or will terminate by reason of the Qualifying Event.

If a formal election is not received by Cigna (or an administrator acting on Cigna's behalf) within this time period, you or your Dependent will not receive Cal-COBRA benefits.

Cal-COBRA Premium Payments

To complete the election process, you must make the first required premium payment no more than 45 days after submitting your completed application to Cigna (or an administrator acting on Cigna's behalf). All subsequent premiums will be due on a monthly basis. Your first premium payment should be delivered to Cigna (or an administrator acting on Cigna's behalf) at Cigna, Attn: State Continuation Unit, P.O. Box 2010, Concord, NH 03302 by first-class mail, certified mail, or other reliable means of delivery. The first premium payment must satisfy any required premiums and all premiums due. Failure to submit the correct premium amount within the 45 day period will disqualify the qualified beneficiary from receiving Cal-COBRA coverage. There is a 30 day grace period to pay subsequent premiums. If the premium is not paid before the expiration of the grace period, Cal-COBRA continuation benefits will terminate at midnight at the end of the period for which premium payments were made.

If elected, the maximum period of continuation coverage for a Qualifying Event is 36 months from the date the qualified beneficiary's benefits under the policy would have otherwise terminated because of the Qualifying Event.

Other events will cause Cal-COBRA benefits to end sooner and this will occur on the earliest of any of the following:

- the date the Employer ceases to provide any group health plan to any Employee;
- the end of the period for which premium payments were made, if the qualified beneficiary ceases to make payments or fails to make timely payments of a required premium, in accordance with the terms and conditions of the policy;

- the first day after the date of election on which the qualified beneficiary first becomes covered under any other group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition for such person; or the date such exclusion or limitation no longer applies to the Employee or Dependent;
- the first day after the date of election on which the qualified beneficiary first becomes entitled to Medicare;
- the coverage for a qualified beneficiary that is determined to be disabled under the Social Security Act will terminate as described below;
- the qualified beneficiary moves out of the service area or the qualified beneficiary commits fraud or deception in the use of services.

Continuation of Coverage for Totally Disabled Individuals

A qualified beneficiary who is eligible for continuation coverage due to termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked so as to render the Employee ineligible for coverage and who is totally disabled under the Social Security Act during the first 60 days of continuation coverage is entitled to a maximum period of 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a Qualifying Event. The Employee or Dependent must provide Cigna (or an administrator acting on Cigna's behalf) with a copy of the Social Security Administration's determination of total disability within 60 days of the date of the determination letter and prior to the end of the original 36 month continuation coverage period in order to be eligible for coverage pursuant to this paragraph. If the qualified beneficiary is no longer disabled under the Social Security Act, the benefits provided in this paragraph shall terminate on the later of 36 months after the date the qualified beneficiary's benefits under the policy would otherwise have terminated because of a Qualifying Event, or the month that begins more than 31 days after the date of the final determination under Social Security Act that the qualified beneficiary is no longer disabled. The qualified beneficiary eligible for 36 months of continuation coverage as a result of a disability shall notify Cigna (or an administrator acting on Cigna's behalf) within 30 days of a determination that the qualified beneficiary is no longer disabled.

Continuation of Coverage Upon Termination of Prior Group Health Plan

The Employer shall notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered as specified above, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled Employees are notified, whichever is later.

Cigna (or an administrator acting on Cigna's behalf) shall provide to the Employer replacing a health plan contract issued by Cigna, or to the Employer's agent or broker representative, within 15 days of any written request, information in possession of Cigna reasonably required to administer the notification requirements of this Notification section.

The Employer shall notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting Employer or administrator, may provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by this Notification section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified beneficiaries who are enrolled in the plan and those qualified beneficiaries who have been notified as specified in this Cal-COBRA section of their ability to continue their coverage and may still elect coverage within the specified 60 day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the Employer by Cigna (or an administrator acting on Cigna's behalf), currently providing continuation coverage to the qualified beneficiary. The successor plan shall not be obligated to provide this information to qualified beneficiaries if the Employer or prior plan fails to comply with this section.

If the plan provides for a conversion privilege, the plan must offer this option within the 180 days of the end of the maximum period. However, no conversion will be provided if the qualified beneficiary does not actually maintain Cal-COBRA coverage to the expiration date.

IMPORTANT NOTICE – CAL-COBRA BENEFITS WILL ONLY BE ADMINISTERED ACCORDING TO THE TERMS OF THE CONTRACT. CIGNA WILL NOT BE OBLIGATED TO ADMINISTER, OR FURNISH, ANY CAL-COBRA BENEFITS AFTER THE CONTRACT HAS TERMINATED.

HC-TRM118 10-16

ET

Medical Benefits Extension

Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury or

Cigna

Sickness, Medical Benefits will be paid without requirement of premium for Covered Expenses incurred in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group policy;
- the date you are no longer Totally Disabled;
- 12 months from the date your Medical Benefits cease;
- 12 months from the date the policy is canceled.

Totally Disabled

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

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

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

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

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

HC-BEX7 04-10
V1-ET

Definitions

Dependent

Dependents are:

- any child of yours who is
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. The plan may require written proof of such disability and dependency within 60 days of receiving our request for written proof. After the original proof is received, the plan may ask for proof of handicap/dependency annually, after the two year period following the child's 26th birthday.

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

HC-DFS1023 10-16
ET2

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-ET

Serious Emotional Disturbances

A Seriously Emotionally Disturbed (SED) child shall be defined as a child who:

- has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance abuse disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms; and
- is under the age of 18 years old; and
- meets the criteria in as follows:
  - as a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
    - the child is at risk of removal from the home or has already been removed from the home;
    - the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
  - the child displays one of the following: psychotic features, risk of suicide or violence due to a mental disorder.
  - the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

HC-DFS168 04-10
V2-ET

Severe Mental Illness

A severe mental illness is defined as: schizophrenia; bipolar disorder; obsessive-compulsive disorder; major depressive disorders; panic disorder; anorexia nervosa; bulimia nervosa; schizoaffective disorder; and pervasive developmental disorder or autism.

HC-DFS169 04-10
V1-ET

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

CERTIFICATE RIDER – Illinois Residents

Rider Eligibility: Each Employee who is located in Illinois

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

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

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

HC-ETILRDR

Important Notices

Illinois Notice

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

Illinois law allows you to select "a woman's principal health care provider" in addition to your selection of a Primary Care Physician. "A woman's principal health care provider" is a Physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice. "A woman's principal health care provider" may be seen for care without referrals from your Primary Care Physician. If you have not already selected "a woman's principal health care provider," you may do so now or at any other time. You are not required to have or to select "a woman's principal health care provider."

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

HC-IMP14 04-10
V1-ET

The Schedule

If your medical plan is subject to a Lifetime Maximum or Preventive Care Maximum, The Schedule is amended to indicate that 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

Covered Expenses

- charges for colorectal cancer screening with sigmoidoscopy or fecal occult blood testing once every 3 years for: persons age 50 and older; or persons age 40 and older who are considered high risks for colorectal cancer.
- charges made for or in connection with low-dose mammography screening including breast tomosynthesis for detecting the presence of breast cancer. Coverage shall include: a baseline mammogram for women ages 35 to 39; an annual mammogram for women age 40 and older; and mammograms at intervals considered Medically Necessary for women less than age 40 who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors. Coverage also includes a comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches as well as a screening MRI when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches.

- low dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device and image receptor, with radiation exposure delivery of less than one rad per breast for two views of an average sized breast. This term also includes digital mammography and includes breast tomosynthesis. The term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.
- charges made for the removal of breast implants when the removal of the implant is Medically Necessary treatment for a sickness or injury.
- charges made for complete and thorough clinical breast exams performed by a Physician licensed to practice medicine in all its branches, an advanced practice nurse who has a collaborative agreement with a collaborating Physician that authorizes breast examinations, or a Physician assistant who has been delegated authority to provide breast examinations. Coverage shall include such an exam at least once every three years for women ages 20 to 40; and annually for women 40 years of age or older.
- charges made for Medically Necessary acute treatment services and Medically Necessary clinical stabilization services. The treating provider shall base all treatment recommendations and Cigna will base all Medically Necessity determinations for Substance Use Disorders in accordance with the most current edition of the American Society of Addiction Medicine Patient Placement Criteria.

  Acute Treatment Services means 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

  Clinical stabilization services means 24-hour treatment, usually following acute treatment services for substance use disorder, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

HC-COV427 05-15

HC-COV763 01-19

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

CERTIFICATE RIDER – Michigan Residents

Rider Eligibility: Each Employee who is located in Michigan

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

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

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

HC-ETMIRDR

Important Notices

Managed Care Disclosure

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

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

HC-IMP91 04-10

V1-ET

The Schedule

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

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

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

SCHEDDENE-ET1

Covered Expenses

The following benefits will be covered for prevention and treatment of diabetes:

- charges for podiatric appliances for prevention of complications associated with diabetes, blood glucose monitors, including for the legally blind, injection aids, insulin pumps and medical supplies required for the use of an insulin pump;
- charges for diabetes self-management training provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the Department of Health, but limited to the following:
  - visits certified as Medically Necessary when diabetes is diagnosed; and
  - visits which are certified to be Medically Necessary following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management.

Autism Spectrum Disorder

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

Cigna, as a condition of coverage may:

- require a review of the treatment consistent with current protocols and may, at its own expense, require a review of the Treatment plan;
- request the results of the Autism Diagnostic Observation Schedule that has been used in the diagnosis of an Autism Spectrum Disorder;
- request that the Autism Diagnostic Observation Schedule be performed not more frequently than once every three years; and
- request that an annual development evaluation be conducted and the results of that annual development evaluation be submitted to Cigna.

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism Diagnostic Observation Schedule means the protocol available through western psychological services for diagnosing and assessing Autism Spectrum Disorders or any other standardized diagnostic measure for Autism Spectrum Disorders that is approved by the commissioner of insurance, if the commissioner of insurance determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

Autism Spectrum Disorders means Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder not otherwise specified, in accordance with the Diagnostic and Statistical Manual (DSM).

Behavioral Health Treatment means evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

- are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
- are provided or supervised by a board certified behavior analyst or a licensed Psychologist so long as the services performed are commensurate with the Psychologist's formal university training and supervised experience.

HC-COV774 01-19
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Medical Pharmaceuticals

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

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

also covered under the plan's medical benefit: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips.

HC-COV553 10-16
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Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the plan, this definition also includes:

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

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

HC-DFS958 10-16
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Definitions

Emergency Services

Emergency services are medical, surgical, Hospital and related health care services, including ground, air, or other ambulance service. Coverage is for medically necessary services for the sudden onset of a medical condition with signs and symptoms so severe, that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to one's body or life, including a pregnancy. Regardless of the diagnosis, benefits will be paid at least to the point of stabilization. Prior authorization is not required.

HC-DFS447 11-10
V1-ET