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

CERTIFICATE RIDER

No. CR7BIASO12-1

Policyholder: University of Richmond

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

Policy No. or Nos. 3340156-OAP

EFFECTIVE DATE: January 1, 2021

You will become insured on the date you become eligible if you are in Active Service on that date or if you are not in Active Service on that date due to your health status. If you are not insured for the benefits described in your certificate on that date, the effective date of this certificate rider will be the date you become insured.

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

Anna Krishtul, Corporate Secretary

HC-RDR1 04-10 V1
The page in your certificate coded HC-PAC73 is replaced by the page coded HC-PAC122 attached to this certificate rider.
The page in your certificate coded HC-PRA41 is replaced by the page coded HC-PRA55 attached to this certificate rider.
The page in your certificate coded HC-COV731 is replaced by the page coded HC-COV976 attached to this certificate rider.
The page in your certificate coded HC-EXC302 is replaced by the page coded HC-EXC406 attached to this certificate rider.
The definitions in your certificate entitled "Charges", “Network Pharmacy” and “Participating Provider” are replaced by the definitions attached to this certificate rider.
The section entitled Coinsurance and Deductible in THE SCHEDULE — Open Access Plus Medical Benefits — in your certificate is changed to read as attached.
The section entitled Physician’s Services in THE SCHEDULE — Open Access Plus Medical Benefits — in your certificate is changed to read as attached.
The section entitled Mental Health and Substance Use Disorder in THE SCHEDULE — Open Access Plus Medical Benefits — in your certificate is changed to read as attached.
The section entitled Virtual Care in THE SCHEDULE — Open Access Plus Medical Benefits — in your certificate is changed to read as attached.
The following is being added to THE SCHEDULE — Open Access Plus Medical Benefits — in your certificate under the section entitled Virtual Care / Dedicated Virtual Providers.
The following is being added to THE SCHEDULE — Open Access Plus Medical Benefits — in your certificate under the section entitled Virtual Care / Virtual Physician Services.
The following is being added to THE SCHEDULE — Open Access Plus Medical Benefits — in your certificate under the section entitled Gene Therapy.
Open Access Plus Medical Benefits
The Schedule

**Coinsurance**
The term Coinsurance means the percentage of Covered Expenses that an insured person is required to pay under the plan in addition to the Deductible, if any.

**Copayments/Deductibles**
Copayments are amounts to be paid by you or your Dependent for covered services. Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this plan. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
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<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
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</thead>
<tbody>
<tr>
<td><strong>Physician’s Services</strong></td>
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<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>$25 per visit copay, then 100%</td>
<td>Plan deductible, then 50%</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>$50 per visit copay, then 100%</td>
<td>Plan deductible, then 50%</td>
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<tr>
<td>Consultant and Referral</td>
<td></td>
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<tr>
<td>Physician’s Services</td>
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<tr>
<td><strong>Note:</strong></td>
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<tr>
<td>OB/GYN providers will be considered either as a PCP or</td>
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<td>Specialist, depending on how the provider contracts</td>
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<tr>
<td>with Cigna on an In-Network basis.</td>
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<tr>
<td>Out-of-Network OB/GYN providers will be considered a</td>
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<tr>
<td>Specialist.</td>
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<tr>
<td>Surgery Performed in the Physician’s Office</td>
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<tr>
<td>Primary Care Physician</td>
<td>$25 per visit copay, then 100%</td>
<td>Plan deductible, then 50%</td>
</tr>
<tr>
<td>Specialty Care Physician</td>
<td>$50 per visit copay, then 100%</td>
<td>Plan deductible, then 50%</td>
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<tr>
<td>Second Opinion Consultations</td>
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<tr>
<td>(provided on a voluntary basis)</td>
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<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>$25 per visit copay, then 100%</td>
<td>Plan deductible, then 50%</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>$50 per visit copay, then 100%</td>
<td>Plan deductible, then 50%</td>
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<tr>
<td>Allergy Treatment/Injections</td>
<td></td>
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<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>$25 per visit copay, then 100%</td>
<td>Plan deductible, then 50%</td>
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<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>$50 per visit copay, then 100%</td>
<td>Plan deductible, then 50%</td>
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<tr>
<td>Allergy Serum (dispensed by the Physician in the office)</td>
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<tr>
<td>Primary Care Physician</td>
<td>100%</td>
<td>Plan deductible, then 50%</td>
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<tr>
<td>Specialty Care Physician</td>
<td>100%</td>
<td>Plan deductible, then 50%</td>
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<tr>
<td><strong>Virtual Care</strong></td>
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<tr>
<td><strong>Dedicated Virtual Providers</strong></td>
<td>Services available through contracted virtual providers as medically appropriate.</td>
<td>$25 per visit copay, then 100%</td>
</tr>
<tr>
<td>Virtual Care Services for minor medical conditions</td>
<td>$25 per visit copay, then 100%</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Virtual Wellness Screenings</td>
<td>100%</td>
<td>In-Network coverage only</td>
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<tr>
<td><strong>Note:</strong></td>
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<tr>
<td>Lab services supporting a virtual wellness screening must be obtained through dedicated labs.</td>
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<tr>
<td><strong>Virtual Physician Services</strong></td>
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<tr>
<td>Services available through Physicians as medically appropriate.</td>
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<tr>
<td><strong>Note:</strong></td>
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<tr>
<td>Preventive services covered at the preventive level.</td>
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<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>$25 per visit copay, then 100%</td>
<td>Plan deductible, then 50%</td>
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<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>$50 per visit copay, then 100%</td>
<td>Plan deductible, then 50%</td>
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<tr>
<td><strong>Gene Therapy</strong></td>
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<tr>
<td>Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary.</td>
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<tr>
<td>Gene therapy must be received at an In-Network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other In-Network facilities is not covered.</td>
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<tr>
<td>Gene Therapy Product</td>
<td>Covered same as Medical Pharmaceuticals</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Plan deductible, then 70%</td>
<td>In-Network coverage only</td>
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<tr>
<td>Outpatient Facility</td>
<td>Plan deductible, then 70%</td>
<td>In-Network coverage only</td>
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<tr>
<td>Inpatient Professional Services</td>
<td>Plan deductible, then 70%</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>Plan deductible, then 100%</td>
<td>In-Network coverage only</td>
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<tr>
<td>Travel Maximum:</td>
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<tr>
<td>$10,000 per episode of gene therapy</td>
<td>100% (available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy)</td>
<td>In-Network coverage only</td>
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<tr>
<td>BENEFIT HIGHLIGHTS</td>
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<tr>
<td><strong>Mental Health</strong></td>
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<tr>
<td><strong>Inpatient</strong></td>
<td>Plan deductible, then 70%</td>
<td>Plan deductible, then 50%</td>
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<tr>
<td>Includes Acute Inpatient and Residential Treatment</td>
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<tr>
<td>Calendar Year Maximum: Unlimited</td>
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<tr>
<td><strong>Outpatient</strong></td>
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<tr>
<td>Outpatient - Office Visits</td>
<td>$25 per visit copay, then 100%</td>
<td>Plan deductible, then 50%</td>
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<tr>
<td>Includes individual, family and group psychotherapy; medication management, virtual care, etc.</td>
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<tr>
<td>Calendar Year Maximum: Unlimited</td>
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<tr>
<td>Outpatient - All Other Services</td>
<td>100%</td>
<td>Plan deductible, then 50%</td>
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<tr>
<td>Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc.</td>
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<td>Calendar Year Maximum: Unlimited</td>
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<tr>
<td><strong>Substance Use Disorder</strong></td>
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<tr>
<td><strong>Inpatient</strong></td>
<td>Plan deductible, then 70%</td>
<td>Plan deductible, then 50%</td>
</tr>
<tr>
<td>Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment</td>
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<tr>
<td>Calendar Year Maximum: Unlimited</td>
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<td><strong>Outpatient</strong></td>
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<tr>
<td>Outpatient - Office Visits</td>
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<td>Outpatient - All Other Services</td>
<td>100%</td>
<td>Plan deductible, then 50%</td>
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Open Access Plus Medical Benefits

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 or Substance Use Disorder Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred will be reduced by 50% 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.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or outpatient procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

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 Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Home Health Care Services.
- Medical Pharmaceuticals.
- Radiation Therapy.

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

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-Standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or outpatient procedures. Outpatient Certification is required prior to any outpatient diagnostic testing or outpatient procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should only be requested for non-emergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will be reduced by 50% 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.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or outpatient procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

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.

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy. Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays.
• inpatient services at any participating Other Health Care Facility.
• residential treatment.
• outpatient facility services.
• partial hospitalization.
• intensive outpatient programs.
• advanced radiological imaging.
• non-emergency Ambulance.
• certain Medical Pharmaceuticals.
• home health care services.
• radiation therapy.
• transplant services.

• charges for outpatient medical care and treatment received at a Free-Standing Surgical Facility.
• charges for Emergency Services.
• charges for Urgent Care.
• charges by a Physician or a Psychologist for professional services.
• charges by a Nurse for professional nursing service.
• charges for anesthetics, including, but not limited to supplies and their administration.
• charges for diagnostic x-ray.
• charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.
• charges for chemotherapy.
• charges for blood transfusions.
• charges for oxygen and other gases and their administration.
• charges for Medically Necessary foot care for diabetes, peripheral neuropathies, and peripheral vascular disease.
• charges for screening prostate-specific antigen (PSA) testing.
• charges for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
• charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
• charges for the following preventive care services as defined by recommendations from the following:
  • the U.S. Preventive Services Task Force (A and B recommendations);
  • the Advisory Committee on Immunization Practices (ACIP) for immunizations;
  • the American Academy of Pediatrics’ Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;
  • the Uniform Panel of the Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children; and
  • with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.

Covered Expenses
The term Covered Expenses means expenses incurred by a person while covered under this plan for the charges listed below for:
• preventive care services; and
• services or supplies that are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna.

As determined by Cigna, Covered Expenses may also include all charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below. Any applicable Copayments, Deductibles or limits are shown in The Schedule.

Covered Expenses
• charges for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital, subject to the limits as shown in The Schedule.
• charges for inpatient Room and Board and other Necessary Services and Supplies made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility as shown in The Schedule.
• charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
• charges for outpatient medical care and treatment received at a Hospital.

HC-PRA55 01-21
Detailed information is available at www.healthcare.gov. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.

- charges for surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.
- charges for the delivery of medical and health-related services and consultations medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.
- behavioral consultations and services via secure telecommunications technologies that shall include video capability, including telephones and internet, when delivered through a behavioral provider.

Nutritional Counseling

Charges for nutritional counseling when diet is a part of the medical management of a medical or behavioral condition.

Enteral Nutrition

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

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

Internal Prosthetic/Medical Appliances

Charges for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Home Health Care Services

- charges made for Home Health Care 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 Care 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 Care 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 Care Services are those skilled health care services that can be provided during visits by Other Health Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Professionals. A visit is defined as a period of 2 hours or less. Home Health Care Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Professionals in providing Home Health Care Services are covered.

Home Health Care 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 Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Care Services benefit terms, conditions and benefit limitations. Outpatient Therapy Services provided in the home are not subject to the Home Health Care Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Outpatient Therapy Services Maximum shown in The Schedule.

Hospice Care Services

- charges for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Room and Board and Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Professional;
    - charges for physical, occupational and speech therapy;
• charges for medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

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

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

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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 Center means an institution which specializes in the treatment of psychological

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

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

Outpatient Mental Health Services

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

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

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

Inpatient Substance Use Disorder Rehabilitation Services

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

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

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

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

**Outpatient Substance Use Disorder Rehabilitation Services**

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

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

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

**Substance Use Disorder Detoxification Services**

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

**Exclusions**

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

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

**Durable Medical Equipment**

- Charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person’s misuse are the person’s responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

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

- **Bed Related Items**: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items**: bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices**: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic
lif ts are covered if patient is two-person transfer), and auto-
tilt chairs.

- **Fixtures to Real Property**: ceiling lifts and wheelchair ramps.

- **Car/Van Modifications**.

- **Air Quality Items**: room humidifiers, vaporizers, air
  purifiers and electrostatic machines.

- **Blood/Injection Related Items**: blood pressure cuffs,
centrifuges, nova pens and needleless injectors.

- **Other Equipment**: heat lamps, heating pads, cryounits,
cryotherapy machines, electronic-controlled therapy units,
ultraviolet cabinets, sheepskin pads and boots, postural
drainage board, AC/DC adaptors, enuresis alarms, magnetic
equipment, scales (baby and adult), stair gliders, elevators,
ausas, any exercise equipment and diathermy machines.

- **External Prosthetic Appliances and Devices**
  - charges made or ordered by a Physician for: the initial
    purchase and fitting of external prosthetic appliances and
devices available only by prescription which are necessary
for the alleviation or correction of Injury, Sickness or
congenital defect.

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

**Prostheses/Prosthetic Appliances and Devices**
Prostheses/prosthetic appliances and devices are defined as
fabricated replacements for missing body parts.
Prostheses/prosthetic appliances and devices include, but are
not limited to:
- limb prostheses;
- terminal devices such as hands or hooks;
- speech prostheses; and
- facial prostheses.

**Orthoses and Orthotic Devices**
Orthoses and orthotic devices are defined as orthopedic
appliances or apparatuses used to support, align, prevent or
correct deformities. Coverage is provided for custom foot
orthoses and other orthoses as follows:
- Non-foot orthoses – only the following non-foot orthoses
  are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid prefabricated and flexible orthoses; and
- rigid prefabricated orthoses including preparation, fitting
  and basic additions, such as bars and joints.

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

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

**Braces**
A Brace is defined as an orthosis or orthopedic appliance that
supports or holds in correct position any movable part of the
body and that allows for motion of that part.
The following braces are specifically excluded: Copes
scoliosis braces.

**Splints**
A Splint is defined as an appliance for preventing movement
of a joint or for the fixation of displaced or movable parts.
Coverage for replacement of external prosthetic appliances
and devices is limited to the following:
- replacement due to regular wear. Replacement for damage
due to abuse or misuse by the person will not be covered.
• replacement required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
• replacement due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited as follows:
• no more than once every 24 months for persons 19 years of age and older.
• no more than once every 12 months for persons 18 years of age and under.

The following are specifically excluded external prosthetic appliances and devices:
• external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
• myoelectric prostheses peripheral nerve stimulators.

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Outpatient Therapy Services
Charges for the following therapy services:

Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy
• Charges for therapy services are covered when provided as part of a program of treatment.

Cardiac Rehabilitation
• Charges for Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient’s status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

Chiropractic Care Services
• Charges for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

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 following criteria are met:
• The individual’s condition has the potential to improve or is improving in response to therapy, and maximum improvement is yet to be attained.
• There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
• The therapy is provided by, or under the direct supervision of, a licensed health care professional acting within the scope of the license.
• The therapy 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.
• charges for Chiropractic Care not provided in an office setting.
• vitamin therapy.
Coverage is administered according to the following:

- Multiple therapy services provided on the same day constitute one day of service for each therapy type.
- A separate Copayment applies to the services provided by each provider for each therapy type per day.

Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

Transplant Services

- charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations. Transplant services include the recipient’s medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

All Transplant services, other than cornea, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are covered at the Out-of-Network level.

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

Transplant Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation and lodging are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); and lodging while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age. The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills;
alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available when the covered person is a donor.

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

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

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

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

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

Gene Therapy
Charges for gene therapy products and services directly related to their administration are covered when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when prior authorized to be received at In-Network facilities specifically contracted with Cigna for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered.

Gene Therapy Travel Services
Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy; and when the gene therapy products and services directly related to their administration are received at a participating In-Network facility specifically contracted with Cigna for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene
therapy related services during any of the following: evaluation, candidacy, event, or post care.

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

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

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

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Clinical Trials

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

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

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

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

- it is federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH).
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Health Care Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).

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

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

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

Examples of routine patient care costs and services include:

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

Clinical trials conducted by Out-of-Network providers will be covered only when the following conditions are met:
• In-Network providers are not participating in the clinical trial; or
• the clinical trial is conducted outside the individual’s state of residence.
Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- charges which you are not obligated to pay for or which you are not billed for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna’s express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. 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 Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.

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.

- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- 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.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- the following services are excluded from coverage regardless of clinical indications: rhinoplasty; blepharoplasty; acupressure; craniosacral/cranial therapy;
dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

- 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. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.

- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.

- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.

- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs is also excluded from coverage.

- reversal of male or female voluntary sterilization procedures.

- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.

- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.

- 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.

- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Care Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.

- private Hospital rooms and/or private duty nursing except as provided under the Home Health Care Services provision.

- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

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

- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.

- aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.

- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses or the first set of eyeglass lenses and frames, and associated services, for treatment of keratoconus or following cataract surgery).

- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

- treatment by acupuncture.

- all non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.

- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- enteral feedings, supplies and specially formulated medical foods that are prescribed and non-prescribed, except for infant formula needed for the treatment of inborn errors of metabolism.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- massage therapy.
- 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. The coverage provided under this plan does not constitute “Qualified Health Coverage” under Michigan law and therefore does not replace Personal Injury Protection (PIP) coverage provided under an automobile insurance policy issued to a Michigan resident. This plan will cover expenses only not otherwise covered by the PIP coverage.

**General Limitations**

No payment will be made for expenses incurred for you or any one of your Dependents:

- for charges by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.

- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges by any covered provider who is a member of your family or your Dependent's family.
- expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.

**Definitions**

**Charges**

The term charges means the actual billed charges; except when Cigna has contracted directly or indirectly for a different amount including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers of such services and/or supplies.

**Network Pharmacy**

A retail or home delivery Pharmacy that has:

- entered into an agreement with Cigna or an entity contracting on Cigna's behalf to provide Prescription Drug Products to plan enrollees.
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- been designated as a Network Pharmacy for the purposes of coverage under your Employer’s plan.
This term may also include, as applicable, an entity that has directly or indirectly contracted with Cigna to arrange for the provision of any Prescription Drug Products the charges for which are Covered Expenses.

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Participating Provider
The term Participating Provider means a person or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies, the Charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the Charges for which are Covered Expenses.

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