University of New England

ANNUAL COMPLIANCE RIDER

EFFECTIVE DATE: January 1, 2025

ACMEM25
3345889

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

Printed in U.S.A.

Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

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

ANNUAL COMPLIANCE RIDER

No. ACMEM25

Policyholder: University of New England

Rider Eligibility: Each Employee

Policy No. or Nos. 3345889-HSAF1/HSAI1, OAP1, OAP2

EFFECTIVE DATE: January 1, 2025

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 annual compliance rider will be the date you become insured.

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

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

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

READ THE FOLLOWING

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

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

Geneva Cambell Brown, Corporate Secretary

Special Plan Provisions

The following text regarding "Policy Provisions" found in the **Special Plan Provisions** section of your medical certificate is being replaced to read as follows:

Policy Provisions

ENTIRE CONTRACT. The entire contract will be made up of the Policy, the Certificate, the application of the Policyholder, a copy of which is attached to the Policy and all subsequent versions of the Policy, the Certificate and the applications, if any, of the Employees.

POLICY CHANGES. Changes may be made in the Policy only by amendment signed by the Policyholder and by the Insurance Company acting through its President, Vice President, Secretary, or Assistant Secretary. No agent may change or waive any terms of the Policy.

STATEMENTS NOT WARRANTIES. All statements made by the Policyholder or by an insured Employee will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or by the Employee to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by the Policyholder or the Employee and a copy is sent to the Policyholder, the Employee or his Beneficiary.

NOTICE OF CLAIM. Written notice of claim must be given to the Insurance Company within 30 days after the occurrence or start of the loss on which claim is based.

If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

CLAIM FORMS. When the Insurance Company receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after the Insurance Company receives notice of claim, he will be considered to have met the proof of loss requirements if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

PROOF OF LOSS. Written proof of loss must be given to the Insurance Company within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible. All claims submitted by providers or participants must be paid, pended or denied within 30 calendar days after receipt of the claim. Written notice to the claimant is required indicating that additional information is needed. Pended claims must be paid or denied within 30 calendar days from receipt of the requested additional information.

PHYSICAL EXAMINATION. The Insurance Company, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require during the pendency of claim under the Policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law.

RIGHT TO KNOW: The Policyholder has the right to obtain information about how the plan operates the care delivery system and an explanation of the benefits to which participants are entitled under the terms of the plan. Additional information regarding the plan may be obtained by contacting the Policyholder's sales office.

LEGAL ACTIONS. No action at law or in equity will be brought to recover on the Policy until at least 60 days after proof of loss has been filed with the Insurance Company. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required by the Policy.

TIME FOR SUITS. There shall be a provision that from the date of issue of a Policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void the Policy or to deny a claim for loss incurred or disability, as defined in the Policy, commencing after the expiration of such 2-year period.

TIME LIMITATIONS. If any time limit set forth in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the state in which the Employee lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

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

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

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

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

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

Federal CAA - Consolidated Appropriations Act

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

Continuity of Care

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

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

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

Appeals

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

Provider Directories and Provider Networks

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

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

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

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

Direct Access to Obstetricians and Gynecologists

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

Selection of a Primary Care Provider

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

Your Rights and Protections Against Surprise Medical Bills

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

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount

charged for a service. This is called "**balance billing**". This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

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

You are protected from balance billing for:

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

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

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

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

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

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

Important Notices

The following text found under **Important Notices** section of your medical certificate has been revised to read as follows:

Designation of Third Party to Receive Notice

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

Right to Reinstatement for Insureds with Cognitive Impairment or Functional Incapacity

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

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

The following text has been added under **Important Notices** section of your medical certificate:

Notice Regarding Comparable Health Care Services

You have the ability to obtain estimated costs for any "Comparable Health Care Services" based on a description of the service or the applicable standard medical codes or current procedural codes used by the American Medical Association. This is available by visiting www.myCigna.com or calling the

toll-free number on your ID card. Comparable Health Care Services are: (1) Physical and Occupational Therapy services; (2) Radiology and imaging services; (3) Laboratory services; and (4) Infusion therapy services.

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

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

Eligibility - Effective Date

The following language regarding "Acquiring a new Dependent" under **Eligibility – Effective Date** section has been added to your medical certificate:

Acquiring a new Dependent

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, custody order or if your Dependent lost eligibility for other coverage, you may request special enrollment. The special enrollment request must be received within 30 days after the occurrence of the special enrollment event. Dependents enrolled due to a special enrollment event will not be considered Late Entrants. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. If the special enrollment event is due to a change in custody of a child coverage will be effective as of the date of the order and coverage as the result of marriage will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

The Schedule

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

Maximum Reimbursable Charge

The Maximum Reimbursable Charge for Out-of-Network services other than those described in The Schedule sections Out-of-Network Charges for Certain Services and Out-of-Network Emergency Services Charges and Out-of-Network Air Ambulance Services Charges is determined based on the lesser of the provider's normal charge for a similar service or supply;

or the amount agreed to by the Out-of-Network provider and Cigna, or a policyholder-selected percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable reimbursement for the same or similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.

SCHED - FED AC111

The Schedule

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

"of the Maximum Reimbursable Charge".

SCHED - FED AC77

The Schedule

The following text is hereby added to the “Preventive Care” section in **The Schedule** of your medical certificate:

Preventive services are covered without cost sharing as provided in state law, but services related to a specific health concern, condition or injury may be separately billed as an office visit and may be subject to cost-sharing requirements as provided in the health plan.

SCHED AC115

The Schedule

The medical schedule is amended to add the provision “Covid-19 screening, testing and vaccinations”.

Covid-19 screening, testing and vaccinations

In-Network benefits will not be subject to any plan deductible and are payable at 100% coinsurance.

Out-of-Network benefits will be subject to any Out-of-Network plan deductible and plan coinsurance.

SCHED AC 104

The Schedule

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

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

Air Ambulance

Subject to any plan coinsurance and plan deductible

SCHED - FED AC 87

The Schedule

The Schedule of your medical certificate is amended to indicate In-Network “Abortion” benefits will be covered at plan deductible, then 100%.

SCHED AC116

The Schedule

The Schedule of your medical certificate is amended to indicate the Out-of-Network coinsurance amount that the plan pays for “Transplant Services and Related Specialty Care” at an Inpatient Facility or for Inpatient Professional Services will be no less than 80%.

SCHED AC117

The Schedule

The following provision, if included in your medical schedule, is hereby removed:

Home Health Care for Mental Health and Substance Use Disorder

SCHED AC 105

Covered Expenses

The following bullet replaces the “hearing aids” bullet shown under **Covered Expenses** in your medical certificate:

- charges made for hearing aids and associated exam for device testing and fitting, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies and delivers speech and other sounds at levels equivalent to that of normal speech and conversations.

The following bullet replaces the “children’s early intervention services” bullet shown under **Covered Expenses** in your medical certificate:

- charges for Children’s Early Intervention Services. Children’s Early Intervention Services are services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified development Disability or delay such as intellectual disabilities, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities.

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

- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits

section for information regarding coverage on oral contraceptives.

The following text regarding "Postpartum Care" is added to the **Covered Expenses** section of your medical certificate:

Postpartum Care

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

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

Covered Expenses

The following language replaces the existing language under "Hospice Care Services" in the **Covered Expenses** section of your medical certificate:

Hospice Care Services

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

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

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

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

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

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

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

Covered Expenses

The following text has been added to the "Mental Health and Substance Use Disorder Services" section found in the **Covered Expenses** section of your medical certificate:

Mental Health and Substance Use Disorder Services

We will not deny treatment for Mental Health and Substance Use Disorder services that use Evidence-Based Practices and are determined to be Medically Necessary health care.

Covered Expenses

External Prosthetic Appliances and Devices

The bullet below has been added under "Prostheses/Prosthetic Appliances and Devices" in the **Covered Expenses - External Prosthetic Appliances and Devices** section of your medical certificate:

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:

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

The Schedule

The pharmacy schedule is amended to add the following:

Insulin Drugs

For all insulin drugs covered by this plan your total out-of-pocket responsibility will not exceed $35 per 30 day supply, regardless of the amount of insulin needed to fill your insulin prescriptions.

SCHEDPHARM90 AC10

Prescription Drug Benefits

The following replaces the corresponding text found in the **Prescription Drug Benefits Covered Expenses** section of your medical certificate.

Covered Expenses

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

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

Prescription Drug Benefits

Prior Authorization Requirements

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

We will approve prior authorization requests for Prescription Drug Products on the Prescription Drug List prescribed to assess or treat a serious mental illness.

Exclusions, Expenses Not Covered and General Limitations

The following exclusion regarding "Hearing Aids" found in the **Exclusions, Expenses Not Covered and General Limitations** section of your medical certificate is hereby NULL and VOID:

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

Medical Benefits Extension Upon Policy Cancellation

The following bullets regarding "Totally Disabled" found in the **Medical Benefits Extension Upon Policy Cancellation** section of your medical certificate have been revised to read as follows:

Totally Disabled

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

- if you were gainfully employed prior to disability, you are unable to engage in any gainful occupation for which you are reasonably suited by training, education, and experience; and
- if you were not gainfully employed prior to disability, you are unable to engage in most normal activities of a person of like age in good health.

Definitions

The following **Disability** definition is being added to the **Definitions** section of your medical certificate:

Disability

A physical, mental, intellectual or developmental Disability that renders a person incapable of self-sustaining employment.

Definitions

The following **Evidence-Based Practices** definition is being added to the **Definitions** section of your medical certificate:

Evidence-Based Practices

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

Definitions

The following language replaces the existing language under "Other Health Professional" in the **Definitions** section of your medical certificate:

Other Health Professional

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

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

Definitions

The following text regarding "Physician" found in the **Definitions** section of your medical certificate is being revised to read as follows:

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued, including but not limited to naturopathic providers, physician assistants, registered nurse first assistants, certified nurse first assistants and certified registered nurse anesthetists if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

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

Federal Requirements

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

HC-FED1 10-10 AC

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits.

Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage elections

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

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

B. Change of status

A change in status is defined as:

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

C. Court order

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

D. Medicare or Medicaid eligibility/entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in cost of coverage

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

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

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

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

G. Reduction in work hours

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

H. Enrollment in a Qualified Health Plan (QHP)

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

Family: A plan may allow an Employee to revoke family coverage midyear in order for family members ("related individuals") to enroll in a QHP through an Exchange (Marketplace). The related individual(s) must be eligible for a Special Enrollment Period to enroll in a QHP or seek to enroll in a QHP during the Marketplace's annual open enrollment period, and the disenrollment from the group plan corresponds to the intended enrollment of the individual(s) in a QHP for new coverage effective beginning no later than the day immediately following the last day of the original coverage. If the Employee does not enroll in a QHP, the Employee must select self-only coverage or family coverage including one or more already-covered individuals.

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Women's Health and Cancer Rights Act (WHCRA)

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

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