



Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

No. CR7BIASO25-1

Policyholder: XL America, Inc.

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

Policy No. or Nos. 3210548-OP1

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 Krishdul, Corporate Secretary

HC-RDR1

04-10
VI



The sections entitled Physician's Services, Outpatient Therapy Services and Chiropractic Services, Acupuncture, Infertility Services, Mental Health and Substance Use Disorder in THE SCHEDULE — Open Access Plus Medical Benefits— in your certificate are changed to read as attached.

The following are being added to THE SCHEDULE — Open Access Plus Medical Benefits— in your certificate under the sections entitled Virtual Care/Dedicated Virtual Providers and Virtual Care/Virtual Physician Services.

The pages in your certificate coded HC-COV731 and HC-EXC302 M are replaced by the pages coded HC-COV976 and HC-EXC406 M attached to this certificate rider.

Open Access Plus Medical Benefits The Schedule

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office Visit	\$10 (Tier 1) or \$25 (non-Tier 1) per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	\$25 (Tier 1) or \$50 (non-Tier 1) per visit copay, then 100%	Plan deductible, then 60%
Consultant and Referral Physician's Services		
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna on an In-Network basis. Out-of-Network OB/GYN providers will be considered a Specialist.		
Surgery Performed in the Physician's Office		
Primary Care Physician	\$10 (Tier 1) or \$25 (non-Tier 1) per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician	\$25 (Tier 1) or \$50 (non-Tier 1) per visit copay, then 100%	Plan deductible, then 60%
Second Opinion Consultations (provided on a voluntary basis)		
Primary Care Physician's Office Visit	\$10 (Tier 1) or \$25 (non-Tier 1) per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	\$25 (Tier 1) or \$50 (non-Tier 1) per visit copay, then 100%	Plan deductible, then 60%
Allergy Treatment/Injections		
Primary Care Physician's Office Visit	\$10 (Tier 1) or \$25 (non-Tier 1) per visit copay, then 100%	Plan deductible, then 60%
Specialty Care Physician's Office Visit	\$25 (Tier 1) or \$50 (non-Tier 1) per visit copay, then 100%	Plan deductible, then 60%
Allergy Serum (dispensed by the Physician in the office)		
Primary Care Physician	100%	Plan deductible, then 60%
Specialty Care Physician	100%	Plan deductible, then 60%

Open Access Plus Medical Benefits
The Schedule

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Virtual Care</p> <p>Dedicated Virtual Providers Services available through contracted virtual providers as medically appropriate.</p> <p>Virtual Care Services for minor medical conditions</p> <p>Virtual Wellness Screenings</p> <p>Note: Lab services supporting a virtual wellness screening must be obtained through dedicated labs.</p> <p>Virtual Physician Services Services available through Physicians as medically appropriate.</p> <p>Note: Preventive services covered at the preventive level.</p> <p>Primary Care Physician’s Office Visit</p> <p>Specialty Care Physician’s Office Visit</p>	<p>\$25 (non-Tier 1) per visit copay, then 100%</p> <p>100%</p> <p>\$10 (Tier 1) or \$25 (non-Tier 1) per visit copay, then 100%</p> <p>\$25 (Tier 1) or \$50 (non-Tier 1) per visit copay, then 100%</p>	<p>In-Network coverage only</p> <p>In-Network coverage only</p> <p>Plan deductible, then 60%</p> <p>Plan deductible, then 60%</p>

Open Access Plus Medical Benefits
The Schedule

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Outpatient Therapy Services and Chiropractic Services</p> <p>Calendar Year Maximum: 90 days for all therapies combined In-Network Only</p> <p>Note: Calendar Year Maximum: 45 days for all therapies combined Out-of-Network Only</p> <p>(The limit is not applicable to mental health conditions.)</p> <p>Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Chiropractic Therapy (includes Chiropractors)</p> <p>Primary Care Physician’s Office Visit</p> <p>Specialty Care Physician’s Office Visit</p>	<p>\$10 (Tier 1) or \$25 (non-Tier 1) per visit copay*, then 100%</p> <p>\$25 (Tier 1) or \$50 (non-Tier 1) per visit copay, then 100%</p> <p>*Note: Outpatient Therapy Services copay applies, regardless of place of service, including the home.</p>	<p>Plan deductible, then 60%</p> <p>Plan deductible, then 60%</p>
<p>Acupuncture</p> <p>Self-referred, Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis, limited to a 20 day maximum per person per Calendar Year</p> <p>Primary Care Physician’s Office Visit</p> <p>Specialty Care Physician’s Office Visit</p>	<p>\$25 (non-Tier 1) per visit copay, then 100%</p> <p>\$50 (non-Tier 1) per visit copay, then 100%</p>	<p>Plan deductible, then 60%</p> <p>Plan deductible, then 60%</p>

Open Access Plus Medical Benefits

The Schedule

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Infertility Services</p> <p>Coverage will be provided for the following services:</p> <ul style="list-style-type: none"> • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination, In-vitro, GIFT, ZIFT, etc. 		
<p>Physician's Office Visit (Lab and Radiology Tests, Counseling)</p> <p style="padding-left: 20px;">Primary Care Physician</p> <p style="padding-left: 20px;">Specialty Care Physician</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Inpatient Professional Services</p> <p style="padding-left: 20px;">Surgeon</p> <p style="padding-left: 20px;">Radiologist, Pathologist, Anesthesiologist</p> <p>Outpatient Professional Services</p> <p style="padding-left: 20px;">Surgeon</p> <p style="padding-left: 20px;">Radiologist, Pathologist, Anesthesiologist</p> <p>Lifetime Maximum: \$40,000 per member</p> <p>Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).</p>	<p>\$10 (Tier 1) or \$25 (non-Tier 1) per visit copay, then 100%</p> <p>\$25 (Tier 1) or \$50 (non-Tier 1) per visit copay, then 100%</p> <p>Plan deductible, then 80%</p> <p>Plan deductible, then 80%</p> <p>Plan deductible, then 90% (Tier 1) or 80% (non-Tier 1)</p> <p>Plan deductible, then 80%</p> <p>Plan deductible, then 90% (Tier 1) or 80% (non-Tier 1)</p> <p>Plan deductible, then 80%</p>	<p>Plan deductible, then 60%</p> <p>Plan deductible, then 60%</p> <p>Plan deductible, then 60%</p> <p>Plan deductible, then 60%</p> <p>Plan deductible, then 60%</p> <p>Plan deductible, then 60%</p> <p>Plan deductible, then 60%</p> <p>Plan deductible, then 60%</p>

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.
- 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.

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

- charges for medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered for an established medical condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Penile implants are not covered as treatment of psychogenic erectile dysfunction.
- charges for acupuncture.
- charges 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 sound.
- 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 as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.
- 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.

HC-COV976

01-21

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 or for which you are not billed or 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.
- 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: abdominoplasty; panniculectomy; 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.
- surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- 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 intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the Body Mass Index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
- 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.
- for treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction, anorgasmia, 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 and dentures.
- 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.
- 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 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.