Loyola University Maryland

ANNUAL COMPLIANCE RIDER

EFFECTIVE DATE: July 1, 2022

ACASOM22
3341746

This document printed in August, 2022 takes the place of any documents previously issued to you which described your benefits.

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

ANNUAL COMPLIANCE RIDER

No. ACASOM22

Policyholder: Loyola University Maryland

Rider Eligibility: Each Employee

Policy No. or Nos. 3341746-HDHFQ/HDHIQ, OAP, OAPIN

EFFECTIVE DATE: July 1, 2022

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 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.

Important Notices

The following **Notice** page regarding "Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) – Non Quantitative Treatment Limitations (NQTLS)" is added to your medical certificate:

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) - Non-Quantitative Treatment Limitations (NQTLs)

Federal MHPAEA regulations provide that a plan cannot impose a Non-Quantitative Treatment Limitation (NQTL) on mental health or substance use disorder (MH/SUD) benefits in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, those used in applying the NQTL to medical/surgical benefits in the same classification of benefits as written and in operation under the terms of the plan.

Non-Quantitative Treatment Limitations (NQTLs) include:

- Medical management standards limiting or excluding benefits based on Medical Necessity or whether the treatment is experimental or investigative;
- Prescription drug formulary design;
- Network admission standards;
- Methods for determining in-network and out-of-network provider reimbursement rates;
- Step therapy a/k/a fail-first requirements; and
- Exclusions and/or restrictions based on geographic location, facility type or provider specialty.

A description of your plan's NQTL methodologies and processes applied to medical/surgical benefits and MH/SUD benefits is available for review by Plan Administrators (e.g. employers) and covered persons by accessing the appropriate link below:

Employers (Plan Administrators): https://cignaaccess.cigna.com/secure/app/ca/centralRepo - Log in, select Resources and Training, then select the NQTL document.

Covered Persons: www.cigna.com\sp

To determine which document applies to your plan, select the relevant health plan product; medical management model (inpatient only or inpatient and outpatient) which can be located in this booklet immediately following The Schedule; and pharmacy coverage (whether or not your plan includes pharmacy coverage).

HC-NOT113 01-20
AC

The Schedule

The following paragraphs regarding "Out-of-Network Charges for Certain Services" are hereby added to **The Schedule** of your medical certificate as a result of the **Consolidated Appropriations Act - No Surprise Bill**:

Out-of-Network Charges for Certain Services

Charges for services furnished by an Out-of-Network provider in an In-Network facility while you are receiving In-Network services at that In-Network facility: (i) are payable at the In-Network cost-sharing level; and (ii) the allowable amount used to determine the Plan's benefit payment is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

SCHED - FED AC70

The Schedule

Any existing paragraphs regarding "Out-of-Network Emergency Services Charges" in **The Schedule** of your medical certificate are hereby replaced as follows as a result of the **Consolidated Appropriations Act - No Surprise Bill**:

Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-Participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network

provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.

3. The allowable amount used to determine the Plan's benefit payment when Out-of-Network Emergency Services result in an inpatient admission is the median amount negotiated with In-Network facilities.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

SCHED - FED AC71

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 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.

Note:

The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable copayment, deductibles and/or coinsurance.

Note:

Some providers forgive or waive the cost share obligation (e.g. your deductible and/or coinsurance) that this plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this plan. For more details, see the Exclusions Section.

SCHED - FED AC78

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 medical schedule is amended to add the provision "Air Ambulance" 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 82

Covered Expenses

The term "Short-Term Rehabilitative Therapy" found in the "Home Health Services" provision in the **Covered Expenses** section of your medical certificate is hereby changed to "Outpatient Therapy Services".

HC-COV863 01-20
AC

Covered Expenses

The following text regarding "Outpatient Therapy Services" replaces the "Short-Term Rehabilitative Therapy and Chiropractic Care Services" text in the **Covered Expenses** section in your medical certificate:

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 Illness, 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 Illness or 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; or
- 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.

HC-COV864 01-20

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Exclusions, Expenses Not Covered and General Limitations

The bullet regarding "Qualified Health Coverage" found in the **Exclusions, Expenses Not Covered and General Limitations** section has been added to your medical certificate:

- 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.

HC-EXC401 07-20
AC

Definitions

The following replaces the definition of "Emergency Services" shown in the **Definitions** section of your medical certificate as a result of the **Consolidated Appropriations Act - No Surprise Bill**:

Emergency Services

Emergency services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to stabilize the patient.

HC-DFS1696 01-22
AC

Definitions

The following replaces the definition of "Maximum Reimbursable Charge - Medical" shown in the **Definitions** section of your medical certificate as a result of the **Consolidated Appropriations Act - No Surprise Bill**:

Maximum Reimbursable Charge - Medical

The Maximum Reimbursable Charge does not apply to Emergency Services.

The Maximum Reimbursable Charge for covered services for Open Access Plus is determined based on the lesser of:

- the provider's normal charge for a similar service or supply;
- the amount agreed to by the Out-of-Network provider and Cigna; or
- a 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 service within the geographic market.

The percentage used to determine the Maximum Reimbursable Charge can be obtained by contacting Member Services/Customer Service.

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;
- the amount agreed to by the Out-of-Network provider and Cigna; 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.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

HC-DFS1631 01-22
AC

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

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.

HC-FED12 10-10
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