

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

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

No. CR7BIASO85-1

Policyholder: Wesleyan University

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

Policy No. or Nos. 3188492-OAP1

EFFECTIVE DATE: January 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 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.


Jill Stadelman, Corporate Secretary

The page in your certificate coded **HC-ELG274M** is replaced by the page coded **HC-ELG274M** attached to this certificate rider.

The pages coded **HC-COV1122, HC-COV1123, HC-COV1180, HC-COV1126** and **HC-DFS1629** attached to this certificate rider are added to your certificate.

The section entitled **Physician's Services, Convenience Care Clinic, Home Health Care Services, Virtual Care, Outpatient Dialysis Services, Mental Health** and **Substance Use Disorder** in THE SCHEDULE — **Open Access Plus Medical Benefits** — in your certificate is changed to read as attached.

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you pay any required contribution.

FACULTY MEMBERS/PROFESSIONAL LIBRARIANS covered if appointed for at least half time (.5FTE or more)

ADMINISTRATIVE STAFF MEMBERS covered if regularly scheduled to work at least half time (at least 975 hours per year).

Secretarial/Clerical/Physical Plant/Public Safety Members: Covered if appointed for at least half time on a non-temporary basis.

DOCTORS AND NURSES EMPLOYED BY THE HEALTH CENTER covered if appointed for at least .5FTE (975 hours) and their employment is expected to last for more than one year.

EARLY RETIREES - FACULTY

- Tenured faculty members who retire on or after July 1 in the calendar year in which the faculty member reaches age 59 and before June 30 following reaching age 68, and who have at least 10 years of continuous eligible service, are eligible to participate in the health plan until the first of the month in which they turn 65.
- Tenured faculty members who retire on or after July 1 in the calendar year in which the faculty member reaches age 55 and whose years of service and age total at least 75 (and who don't meet the eligibility outlined in the first bullet), are eligible to participate in the health plan until the first of the month in which they turn 65.
- Adjunct faculty, Artists in Residence and Professors of the Practice who retire on or after age 55 and whose years of service and age total at least 75 are eligible to participate in the health plan until the first of the month in which they turn 65.

EARLY RETIREES - STAFF

- Staff members who retire on or after age 55 and whose number of years of service and age total at least 75 may continue to participate in the health plan until the 1st of the month in which they turn age 65.
- Staff members who were hired prior to July 1, 2001 and who retire between ages 60 and the 65 with at least 10 years of

continuous eligible service may also continue to participate in health plan until the first of the month when they turn age 65. Add Category - Early Retirement -Secretarial/Clerical Staff: Members of the secretarial/clerical bargaining unit who retire on or after age 55 and whose number of years of service and age total at least 75 may continue to participate in the health plan until the first of the month in which they turn age 65.

EARLY RETIREMENT PUBLIC SAFETY STAFF

- Public Safety retirees who retire on or after age 55 and whose number of years of service and age total at least 75 may continue to participate in the health plan until the first of the month in which they turn age 65.
- Full-time employees who were hired prior to July 1, 2001 and who retire between ages 60 and 65 with at least ten years of continuous service may also continue to participate in the health plan until the first of the month in which they turn age 65 even though their number of years of service and age do not equal 75.

EARLY RETIREMENT PHYSICAL PLANT STAFF

The University will continue group insurance coverage for Physical Plant bargaining unit members who retire at age 60 or older with at least ten (10) years of service until the first of the month in which they reach age 65. Eligibility for this coverage will cease if the retiree undertakes employment elsewhere in which he or she is eligible for insurance coverage under the other employer's plan.

Early retirees will be billed for coverage on a monthly basis. Coverage will be cancelled if the premium is not paid according to the billing terms. If a retiree chooses to end coverage or coverage is cancelled due to non-payment prior to the periods allowed above, they cannot choose to re-enter the plan later. Early retirees' dependents & spousal/domestic partner coverage: If covered at the time of the member's retirement, the non-spouse/non-domestic partner dependents of an early retiree can be covered until the end of the month in which they turn 26 or the first of the month in which the retiree (or the spouse/domestic partner if they are covered longer than the retiree) turns 65, whichever is earlier. If the dependent is fully disabled, coverage ends the first of the month in which the retiree (or their spouse/domestic partner if they are covered longer than the retiree) turns 65 or until the dependent is no longer fully disabled, whichever occurs first. If covered by the plan at the time of the member's retirement, the spouse/domestic partner can continue coverage until Medicare eligible. If the spouse/domestic partner is Medicare-eligible at the time of the member's retirement, they are not eligible to continue coverage. If a dependent chooses to end coverage or coverage is cancelled due to non-payment prior to the periods allowed above, they cannot choose to re-enter the plan later.

For ACA employees, those who meet the ACA eligibility look back criteria are eligible to enroll for the following policy plan year.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Eligibility for Dependent Insurance

You will become eligible for Dependent Insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

None.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

Coverage is effective on the date of hire for new employees and on the date of a status change for employees moving into a benefits-eligible position. Your election must be made

within 31 days of your eligibility date and you are responsible for premiums retroactive to the eligibility date.

Dependent Insurance

If you are newly eligible and you have elected to cover your dependent(s), your dependent(s) are covered on your eligibility date. You may not cover your dependent(s) without covering yourself. If you are adding coverage for your dependent(s) due to a life status event, you must make your election to cover the dependent(s) within 31 days of the qualifying life event and you are responsible for premiums retroactive to the qualifying life event.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Exception for Newborns

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

Open Access Plus Medical Benefits		
The Schedule		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office Visit	No charge after \$25 per office visit copay	70% of the Maximum Reimbursable Charge after plan deductible
Specialty Care Physician's Office Visit	No charge after \$35 Specialist per office visit copay	70% of the Maximum Reimbursable Charge after plan deductible
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	No charge after the \$25 PCP or \$35 Specialist per office visit copay	70% of the Maximum Reimbursable Charge after plan deductible
Specialty Care Physician	No charge after either the \$25 PCP or \$35 Specialist per office visit copay or the actual charge, whichever is less	70% of the Maximum Reimbursable Charge after plan deductible
Second Opinion Consultations (provided on a voluntary basis)		
Primary Care Physician's Office Visit	No charge after the \$25 PCP or \$35 Specialist per office visit copay	70% of the Maximum Reimbursable Charge after plan deductible
Specialty Care Physician's Office Visit	No charge after either the \$25 PCP or \$35 Specialist per office visit copay or the actual charge, whichever is less	70% of the Maximum Reimbursable Charge after plan deductible
Allergy Treatment/Injections		
Primary Care Physician's Office Visit	No charge after the \$25 PCP or \$35 Specialist per office visit copay	70% of the Maximum Reimbursable Charge after plan deductible
Specialty Care Physician's Office Visit	No charge after either the \$25 PCP or \$35 Specialist per office visit copay or the actual charge, whichever is less	70% of the Maximum Reimbursable Charge after plan deductible

Open Access Plus Medical Benefits		
The Schedule		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Allergy Serum (dispensed by the Physician in the office)</p> <p>Primary Care Physician</p> <p>Specialty Care Physician</p>	<p>No charge after the \$25 PCP or \$35 Specialist per office visit copay</p> <p>No charge after either the \$25 PCP or \$35 Specialist per office visit copay or the actual charge, whichever is less</p>	<p>70% of the Maximum Reimbursable Charge after plan deductible</p> <p>70% of the Maximum Reimbursable Charge after plan deductible</p>
<p>Convenience Care Clinic</p>	<p>No charge after the \$25 per office visit copay</p>	<p>70% of the Maximum Reimbursable Charge after plan deductible</p>
<p>Virtual Care</p> <p>Dedicated Virtual Providers Services available through contracted virtual providers as medically appropriate.</p> <p>Urgent Virtual Care Services</p> <p>Notes: Dedicated Virtual Providers may deliver services that are payable under other benefits (e.g., Preventive Care, Primary Care Physician, Behavioral; Dermatology/Specialty Care Physician).</p> <p>Lab services supporting a virtual visit must be obtained through dedicated labs.</p> <p>Virtual Physician Services Services available through Physicians as medically appropriate.</p> <p>Note: Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services)</p> <p>Primary Care Physician Virtual Office Visit</p> <p>Specialty Care Physician Virtual Office Visit</p>	<p>No charge after the \$25 PCP per office visit copay</p> <p>No charge after the \$25 PCP or \$35 Specialist per office visit copay</p> <p>No charge after the \$25 PCP or \$35 Specialist per office visit copay</p>	<p>In-Network coverage only</p> <p>70% of the Maximum Reimbursable Charge after plan deductible</p> <p>70% of the Maximum Reimbursable Charge after plan deductible</p>

Open Access Plus Medical Benefits		
The Schedule		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Home Health Care Services</p> <p>Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as Medically Necessary)</p> <p>Dialysis visits in the home setting will not accumulate to the Home Health Care maximum</p>	100% after plan deductible	70% of the Maximum Reimbursable Charge after plan deductible
<p>Outpatient Dialysis Services</p> <p>Physician's Office Visit</p> <p>Outpatient Facility</p> <p>Physician's Services</p> <p>Home Setting</p>	<p>No charge after the \$25 PCP or \$35 Specialist per office visit copay</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p>	<p>70% of the Maximum Reimbursable Charge after plan deductible</p> <p>70% of the Maximum Reimbursable Charge after plan deductible</p> <p>70% of the Maximum Reimbursable Charge after plan deductible</p> <p>70% of the Maximum Reimbursable Charge after plan deductible</p>
<p>Mental Health</p> <p>Inpatient</p> <p>Includes Acute Inpatient and Residential Treatment</p> <p>Calendar Year Maximum: Unlimited</p> <p>Outpatient</p> <p>Outpatient - Office Visits</p> <p>Includes individual, family and group psychotherapy; medication management, virtual care, etc.</p> <p>Calendar Year Maximum: Unlimited</p> <p>Outpatient - All Other Services</p> <p>Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc.</p> <p>Calendar Year Maximum: Unlimited</p>	<p>100% after plan deductible</p> <p>\$35 per visit copay</p> <p>100% after plan deductible</p>	<p>70% of the Maximum Reimbursable Charge after plan deductible</p> <p>70% of the Maximum Reimbursable Charge after plan deductible</p> <p>70% of the Maximum Reimbursable Charge after plan deductible</p>

Open Access Plus Medical Benefits

Covered Expenses

Virtual Care

Dedicated Virtual Providers

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.

Virtual Physician Services

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.

Charges for behavioral consultations and services via secure telecommunications technologies that shall include video capability, including telephones and internet, when delivered through a behavioral provider.

Convenience Care Clinic

Convenience Care Clinics provide for common ailments and routine services, including but not limited to, strep throat, ear infections or pink eye, immunizations and flu shots.

HC-COV1122

01-22

Home Health Care Services

Charges for skilled care provided by certain health care providers during a visit to the home, when the home is determined to be a medically appropriate setting for the services. 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.

Home Health Care Services are covered when skilled care is required under any of the following conditions:

- the required skilled care cannot be obtained in an outpatient facility.
- confinement in a Hospital or Other Health Care Facility is not required.
- the patient's home is determined by Cigna to be the most medically appropriate place to receive specific services.

Covered services include:

- skilled nursing services provided by a Registered Nurse (RN), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse (APRN).

- services provided by health care providers such as physical therapist, occupational therapist and speech therapist.
- services of a home health aide when provided in direct support of those nurses and health care providers.
- necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.

Note: Physical, occupational, and other Outpatient Therapy Services provided in the home are covered under the Outpatient Therapy Services benefit shown in The Schedule.

The following are excluded from coverage:

- services provided by a person who is a member of the patient's family, even when that person is a health care provider.
- services provided by a person who normally resides in the patient's house, even when that person is a health care provider.
- non-skilled care, Custodial Services, and assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other services; self-care activities; homemaker services; and services primarily for rest, domiciliary or convalescent care.

Home Health Care Services, for a patient who is dependent upon others for non-skilled care and/or Custodial Services, is provided only when there is a family member or caregiver present in the home at the time of the health care visit to provide the non-skilled care and/or Custodial Services.

HC-COV1123

01-22

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.

Hospice Care Programs rendered by Hospice Facilities or Hospitals include 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;

Hospice Care Programs rendered by Other Health Care Facilities or in the Home include services:

- for part-time or intermittent nursing care by or under the supervision of a Nurse;
- for part-time or intermittent services of an Other Health Professional;
- physical, occupational and speech therapy;
- medical supplies;
- drugs and medicines lawfully dispensed only on the written prescription of a Physician;
- laboratory services;
- Life expectancy expanded from 6 months to 12 months
- Expanded Hospice Care to include those still receiving curative care and treatment.

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.

HC-COV1180

01-22

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.

HC-COV481

12-15

covered. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant, the transplant recipient's plan would cover all donor costs.

HC-COV1126

01-22

Definitions

Convenience Care Clinics

Convenience Care Clinics are staffed by nurse practitioners and physician assistants and offer customers convenient, professional walk-in care for common ailments and routine services. Convenience Care Clinics have extended hours and are located in or near easy-to-access, popular locations (pharmacies, grocery and free-standing locations) with or without appointment.

HC-DFS1629

07-21