

Wake County Government

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: June 1, 2021

ETALLM21B
3341120

This document printed in June, 2021 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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

CERTIFICATE RIDER

Policyholder: Wake County Government
Rider Eligibility: Each Employee as noted within this certificate rider
Policy No. or Nos.: 3341120
Effective Date: June 1, 2021

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

IMPORTANT INFORMATION

For Residents of States other than the State of North Carolina:

State-specific riders contain provisions that may add to or change your certificate provisions.

The provisions identified in your state-specific rider, attached, are ONLY applicable to Employees residing in that state. The state for which the rider is applicable is identified at the beginning of each state specific rider in the "Rider Eligibility" section.

Additionally, the provisions identified in each state-specific rider only apply to:

- (a) Benefit plans made available to you and/or your Dependents by your Employer;
- (b) Benefit plans for which you and/or your Dependents are eligible;
- (c) Benefit plans which you have elected for you and/or your Dependents;
- (d) Benefit plans which are currently effective for you and/or your Dependents.

Please refer to the Table of Contents for the state-specific rider that is applicable for your residence state.


Anna Krishtul, Corporate Secretary

HC-ETDRD



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

CERTIFICATE RIDER – Arizona Residents

Rider Eligibility: Each Employee who is located in Arizona

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Arizona for group insurance plans covering insureds located in Arizona. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETAZRDR

When You Have a Complaint or an Appeal

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems. The Appeals Process Information Packet (“Appeal Packet”) describes the process by which Members may obtain information and submit concerns regarding service, benefits, and coverage. For more information, see the Appeals Process Information Packet (“Appeal Packet”).

We will provide you a copy of the Appeal Packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call Customer Services at the toll-free number that appears on your Benefit Identification card.

HC-APL277

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

CERTIFICATE RIDER – Arkansas Residents

Rider Eligibility: Each Employee who is located in Arkansas

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Arkansas for group insurance plans covering insureds located in Arkansas. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETARRDR

Eligibility – Effective Date

Dependent Insurance

Exception for Adopted Children

Any Dependent child adopted by you while you are insured will become insured from the date the adopted child is placed with you, or from the date you file the petition for adoption, if you elect Dependent Insurance no later than 90 days from the date of the petition for adoption, or from the date of placement, whichever is later. A newborn adopted child will become insured from the moment of birth, if the petition is

filed and if you elect Dependent Insurance no later than 90 days from the child's birth.

If you do not elect to insure your adopted child within such 90 days, or if your petition for adoption is dismissed or denied, no benefits for expenses incurred beyond the 90th day following placement or filing of the petition to adopt, whichever is later, will be payable.

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Covered Expenses

- charges made for anesthesia, hospitalization services and/or ambulatory surgical facility charges performed in connection with dental procedures when such services are required to effectively perform the procedures and the patient is:
 - under seven years of age and it is determined by two dentists that treatment in a Hospital or ambulatory surgical center is required without delay due to a significantly complex dental condition;
 - a person with a serious diagnosed mental or physical condition; or
 - a person with a significant behavioral problem as determined by their Physician.
- charges for colorectal cancer examinations and laboratory tests for covered persons who are fifty years of age or older; less than fifty years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; or are experiencing the following symptoms of colorectal cancer as determined by a Physician: bleeding from the rectum or blood in the stool; or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five days.

The colorectal screening shall involve an examination of the entire colon, including the following examinations and laboratory tests:

- an annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five years;
- a double-contrast barium enema every five years; or
- a colonoscopy every ten years; and any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, as determined in consultation with appropriate health care organizations.

- charges for prostate cancer examinations and laboratory tests once a year for non-symptomatic covered persons who are forty years of age or older in accordance with the National Comprehensive Cancer Guidelines.

The following applies only to state employees and public school employees:

- charges for diagnosis and treatment of autism spectrum disorder, as defined in the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders".

The following treatment is covered when Medically Necessary and evidence-based:

- applied behavior analysis;
- pharmacy care;
- psychiatric care;
- psychological care;
- therapeutic care;
- equipment determined necessary to provide evidence-based treatment;
- any care determined to be Medically Necessary and evidence-based.
- in addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below for a Dependent child who is age 18 or less, for charges made for Child Preventive Care Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:
 - a history;
 - physical examination;
 - development assessment;
 - anticipatory guidance;
 - appropriate immunizations, which are not subject to any copay, coinsurance, deductible, or dollar limit; and
 - laboratory tests;

excluding any charges for:

- more than one visit to one provider for Child Preventive Care Services at each of the Approximate Age Intervals up to a total of 20 visits for each Dependent child;
- services for which benefits are otherwise provided under this Comprehensive Medical Benefits section;
- services for which benefits are not payable according to the Expenses Not Covered section.

Approximate Age Intervals are: Birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years.

- 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 made for corrective surgery and related medical care for Covered Persons of any age diagnosed as having a craniofacial anomaly if the surgery and treatment are Medically Necessary to improve a functional impairment, as determined by a nationally accredited cleft-craniofacial team. Medical care coverage includes dental care, vision care, and the use of at least one hearing aid. Craniofacial anomaly means a congenital or acquired musculoskeletal disorder that primarily affects the cranial facial tissue.
- charges for gastric pacemakers to treat gastroparesis, a neuromuscular stomach disorder in which food empties into the stomach more slowly than normal.

Medical Telehealth/Telemedicine - PCP/Specialist

- charges for the delivery of real-time healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient provided via secure internet-based audio and video technologies, including store-and-forward technology and remote patient monitoring, which are similar to office visit services provided in a face-to-face setting. It does not include the use of telephone alone, or audio-only communication, including without limitation interactive audio; a facsimile machine; text messaging, or electronic mail systems.

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Prescription Drug Benefits

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

After satisfying the plan Deductible, if any, your responsibility for a covered Prescription Drug Product subject to a Copayment requirement will always be the lowest of:

- the Copayment for the Prescription Drug Product; or
- the Prescription Drug Charge for the Prescription Drug Product; or

- the Pharmacy's Usual and Customary (U&C) Charge for the Prescription Drug Product.

HC-PHR254

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When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service Toll-Free Number that appears on your benefit identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Cigna has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing, within 365 days of receipt of a denial notice, to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your benefit identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals

involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

Cigna's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

If the appeal involves a coverage decision based on issues of Medical Necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician Reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician Reviewer. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was not involved in any previous decision related to your appeal, and not a subordinate of previous decision makers. Provide all relevant documentation with your second level appeal request.

For required preservice and concurrent care coverage determinations, Cigna's review will be completed within 15 calendar days. For postservice claims, Cigna's review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You will be notified in writing of the decision within five working days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in

the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician Reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a standard external review, you or your authorized representative must file a written request for an external review with the Arkansas Insurance Commissioner within four (4) months after the date of receipt of a notice of adverse determination. The Arkansas Insurance Department has prescribed a form to be used to request an external review. This form will be included as an attachment to all Medical Necessity initial and appeal denial letters.

Requests for an expedited external review may be made orally or in writing to the Arkansas Insurance Commissioner. An expedited external review may be requested if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal review would seriously jeopardize the life or health of the covered person and a request for expedited internal review has been filed or the adverse determination involves emergency services and the covered person has not been discharged from a facility.

If the request for expedited external review involved a treatment denied as experimental or investigational, the treating Physician must certify in writing that the recommended or requested service would be significantly less effective if not promptly initiated.

Retrospective (post service) adverse determinations are not eligible for expedited external review.

Within 1 business day after receipt of a request for a standard external review by an Independent Review Organization, the Arkansas Insurance Department sends a copy of the request to Cigna. If the request is for an Expedited External Review, the Arkansas Insurance Department will forward the request to Cigna immediately.

Within 5 business days of receipt of the copy of the request (immediately for request for expedited external review), Cigna will complete a preliminary review to determine whether:

- You were a covered person under the plan on the date service was requested (pre-service review) or on the date of service (concurrent or retrospective review). Retrospective reviews are eligible for standard external reviews, but are not eligible for expedited external reviews.
- The service is the subject of an adverse determination.
- The service is a covered benefit under the health plan.
- The internal appeal process has been exhausted (this requirement is waived for request for expedited external review).
- All the information and forms required to process the external review have been provided, including the Release of Medical Information section of the Arkansas External Review Request form.
- In cases of experimental or investigational denials, the review must also include a determination that:
 - The service would be a covered service except for the determination that the service is experimental or investigational.
 - The service is not explicitly listed as an excluded benefit under the health plan.
 - The treating physician has certified that standard health care services or treatments have not been effective; or standard health care services or treatments are not medically appropriate for the covered person; or there is no available standard health care service or treatment that is more beneficial than the requested service.
 - Either the treating physician or a licensed board certified/eligible physician qualified to practice in the area of medicine appropriate to the covered person's condition certifies in writing that the requested treatment is likely to be more beneficial than available standard services or treatments.

The treating physician certification form is included as part of the Arkansas External Review Request form.

- If an expedited external review is being requested, the treating healthcare provider must complete the Certification of Treating Health Care Provider for

Expedited Consideration of a Patient's External Review Appeal form. This form is included as part of the Arkansas External Review Request.

Within one (1) business day after completion of the preliminary review, Cigna will notify the Arkansas Insurance Department, and you (or your authorized representative) in writing, that the review is complete and if the request is eligible for external review.

Within one (1) business day after receipt of Cigna's notice that a covered person is eligible for a standard external review (or immediately for an expedited external review), the Arkansas Insurance Department will randomly assign each request for external review to the Independent Review Organization (IRO).

Within forty-five (45) days after the date of receipt of request for standard external review, the IRO will provide written notice of its decision to you (or your authorized representative), Cigna and the Arkansas Department of Insurance.

As expeditiously as possible, but in no event more than seventy two (72) hours after the date of receipt of request for expedited external review, the IRO will provide notice to you (or your authorized representative), Cigna and the Arkansas Department of Insurance of its decision. If initial notice is not in writing, within forty-eight (48) hours of the verbal notice, the IRO must provide written notification of the decision.

If the IRO decision reverses Cigna's adverse determination, Cigna must immediately approve the coverage under the terms of the health benefit plan.

If the IRO decision upholds Cigna's adverse determination, the IRO decision is binding on both Cigna and you, except to the extent you have other remedies available under State or Federal law.

Once the IRO makes an external review decision, additional requests for external review for the same adverse determination may not be made.

Appeal to the State of Arkansas

You have the right to contact the Arkansas Insurance Department for assistance at any time. The Consumer Services Division may be contacted at the following address and telephone number:

Arkansas Insurance Department
Consumer Services Division
Third and Cross Streets
Little Rock, AR 72201
501-371-2640
501-371-2749 Fax
or call: 1-800-852-5494

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two appeal process prior to bringing legal action. However, no action will be brought at all unless brought within three years after a claim is submitted for In-Network services.

HC-APL123

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Definitions

Dependent

The term child means a child born to you or a child legally adopted by you from the date you file a petition for adoption.

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Prescription Drug Charge

The amount Cigna charges to the Plan, including the applicable dispensing fee and any applicable sales tax and prior to application of any Deductible, Copayment or Coinsurance amounts, for a Prescription Drug Product dispensed at a Network Pharmacy. Cigna may pay a Network Pharmacy a different amount for a Prescription Drug Product than the Plan pays to Cigna. You are not entitled to the difference between the rate Cigna charges to the Plan and the rate Cigna pays to the Pharmacy for a Prescription Drug Product. For the purposes of Prescription Drug benefit payments, the "Plan" is the entity or business unit responsible for funding benefits in accordance with the terms and conditions outlined in this booklet/certificate.

HC-DFS1092

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

CERTIFICATE RIDER – Colorado Residents

Rider Eligibility: Each Employee who is located in Colorado

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Colorado group insurance plans covering insureds located in Colorado. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETCORDER

Definitions

Dependent

Dependents include:

- your lawful spouse or your partner in a Civil Union;

HC-DFS910

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Emergency Service Provider

The term Emergency Service Provider means a local government, or an authority formed by two or more local governments, that provide fire-fighting and fire prevention services, emergency medical services, ambulance services, or search and rescue services, or a not-for-profit non-governmental entity organized for the purpose of providing any such services, through the use of bona fide volunteers.

HC-DFS236

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VI-ET

Employee

The term Employee means a full-time Employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 0 hours a week for the Employer. The term Employee may include officers, managers and Employees of the Employer, the bona fide volunteers if the Employer is an Emergency Service Provider, the partners if the Employer is a partnership, the officers, managers, and Employees of subsidiary or affiliated corporations of a corporation Employer, and the individual proprietors, partners, and Employees of individuals and firms, the business of which is controlled by the insured Employer through stock ownership, contract, or otherwise.

HC-DFS1096

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Employer

The term Employer means the Policyholder and all Affiliated Employers. The term Employer may include an Emergency Service Provider, any municipal or governmental corporation, unit, agency or department thereof, and the proper officers, as such, of an Emergency Service Provider or an unincorporated municipality or department thereof, as well as private individuals, partnerships, and corporations.

HC-DFS240

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VI-ET

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

CERTIFICATE RIDER – Connecticut Residents

Rider Eligibility: Each Employee who is located in Connecticut

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Connecticut group insurance plans covering insureds located in Connecticut. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETCTDR

Definitions

Dependent

Federal rights may not be available to same-sex spouses, or Civil Union partners or Dependents.

Connecticut law allows same-sex marriages, and grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons of the opposite sex under federal law may not be available to same-sex spouses, or parties to a civil union.

HC-DFS673

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

CERTIFICATE RIDER – Delaware Residents

Rider Eligibility: Each Employee who is located in Delaware

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Delaware group insurance plans covering insureds located in Delaware. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETDERDR

Prior Authorization/Pre-Authorized

Coverage includes immediate access, without Prior Authorization, to a 5-day emergency supply of covered, prescribed medications for the Medically Necessary treatment of serious mental illnesses and Drug and Alcohol Dependencies, where an Emergency Medical Condition exists. The emergency supply requirement includes prescribed medications for opioid overdose reversal that are otherwise covered under the health benefit plan.

HC-PRA44

01-19
VI-ET

Covered Expenses

- charges made for or in connection with one baseline lead poison screening test for Dependent children at or around 12 months of age, or in connection with lead poison screening and diagnostic evaluations for Dependent children under the age of 6 years who are at high risk for lead poisoning according to guidelines set by the Division of Public Health.
- hearing loss screening tests of newborns and infants provided by a Hospital before discharge.
- charges made for treatment of serious mental illness. Such Covered Expenses will be payable the same as for other illnesses. Any mental illness maximums in The Schedule and any Full Payment Area exceptions for mental illness will not apply to serious mental illness.
- scalp hair prostheses and wigs worn due to alopecia areata.

HC-COV969

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The Schedule

The pharmacy Schedule is amended to indicate the following:

You may receive coverage for up to a 90-day supply of a covered Prescription Drug Product dispensed by a Retail Network Pharmacy or a Home Delivery Network Pharmacy. The amount you pay for a up to 90-day supply of a Prescription Drug Product at a Retail Network Pharmacy or a Home Delivery Network Pharmacy will be the same Coinsurance as a Retail Network Pharmacy.



If Specialty Drugs are limited to a 30-day supply at a Home Delivery Network Pharmacy then the following will apply:
 Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill and are subject to the same Copayment or Coinsurance that applies to Retail Pharmacies.

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Prescription Drug Benefits

Limitations

Emergency Supplies of Prescription Drug Products

Coverage includes immediate access, without prior authorization, to a 5-day emergency supply of covered, prescribed medications for the Medically Necessary treatment of serious mental illnesses and Drug and Alcohol Dependencies, where an Emergency Medical Condition exists. The emergency supply requirement includes prescribed medications for opioid overdose reversal that are otherwise covered under the health benefit plan.

HC-PHR409

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Definitions

Drug and Alcohol Dependencies

Drug and Alcohol Dependencies means Substance Abuse Disorder or the chronic, habitual, regular, or recurrent use of alcohol, inhalants, or controlled substances as identified in Delaware law.

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

CERTIFICATE RIDER – Florida Residents

Rider Eligibility: Each Employee who is located in Florida

The benefits of the policy providing your coverage are primarily governed by the law of a state other than Florida.

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Florida group insurance plans covering insureds located in Florida. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETFLRDR

Eligibility - Effective Date

Dependent Insurance

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, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included. A newborn child will be covered for the first 31 days of life even if you fail to enroll the child. If you enroll the child after the first 31 days and by the 60th day after his birth, coverage will be offered at an additional premium. Coverage for an adopted child will become effective from the date of placement in your home or from birth for the first 31 days even if you fail to enroll the child. However, if you enroll the adopted child between the 31st and 60th days after his birth or placement in your home, coverage will be offered at an additional premium.

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Covered Expenses

- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: a baseline mammogram for women ages 35 through 39; a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; a mammogram every year for women age 50 and over; and one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician's recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.
- charges made for diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint. Appliances and non-surgical treatment including for orthodontia are not covered.
- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.
- charges for general anesthesia and hospitalization services for dental procedures for an individual who is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which

patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.

- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.
- charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: have vertebral abnormalities; are receiving long-term glucocorticoid (steroid) therapy; have primary hyperparathyroidism; have a family history of osteoporosis; and/or are estrogen-deficient individuals who are at clinical risk for osteoporosis.
- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be Medically Necessary by the Physician and in consultation with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.
- charges for newborn and infant hearing screening as well as any medically necessary follow-up evaluations leading to diagnosis and subsequent medically necessary treatment of a diagnosed hearing impairment.
- charges for the coverage of child health supervision services from birth to age 16. Child health supervision services are physician-delivered or supervised services that include periodic visits which include a history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests.

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Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by Cigna only to a person who:

- resides in a state that requires offering a conversion policy,
- is Entitled to Convert, and

- applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled to Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased but only if:

- you are not eligible for other individual insurance coverage on a guaranteed issue basis.
- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

If you retire, you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for other individual insurance coverage on a guaranteed issue basis, is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has

not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy

If you reside in a state that requires the offering of a conversion policy, the Converted Policy will be one of Cigna's current conversion policy offerings available in the state where you reside, as determined based upon Cigna's rules.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are Entitled to Convert, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

Medical Benefits Extension Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury, Sickness or pregnancy, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury, Sickness or pregnancy. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date a succeeding carrier agrees to provide coverage without limitation for the disabling condition;
- the date you are no longer Totally Disabled;
- 12 months from the date the policy is canceled; or
- for pregnancy, until delivery.

Totally Disabled

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

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

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

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

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Definitions

Dependent – For Medical Insurance

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. Coverage is not required if the adopted child is ultimately not placed in your home.

A child includes a child born to an insured Dependent child of yours until such child is 18 months old.

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

CERTIFICATE RIDER – Georgia Residents

Rider Eligibility: Each Employee who is located in Georgia

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Georgia group insurance plans covering insureds located in Georgia. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

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When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care and services you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service toll-free number that appears on your

Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice.

If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a post service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services.

Cigna's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary.

When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Step Therapy Override Appeals

Cigna will grant or deny a step therapy exception or appeal of a step therapy exception within:

- twenty-four hours in an urgent health care situation; and
- two business days from the date such request or appeal is submitted in a non-urgent health care situation.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Requests for a level two appeal regarding the Medical Necessity or clinical appropriateness of your issue will be conducted by a Committee, which consists of at least three people not previously involved in the prior decision. The Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by Cigna's Physician Reviewer. You may present your situation to the Committee in person or by conference call.

For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

You will be notified in writing of the Committee's decision within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician Reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

You are entitled to a prompt and meaningful hearing for issues related to a denial, in whole or in part, of a health care service, treatment, or claim following exhaustion of all standard appeals requirements. The grievance hearing will be conducted by a panel of not less than 3 persons, including a Physician other than the medical director of the Plan, and a

health care provider competent in the treatment or procedure which has been denied. You will be provided prompt notice in writing of the resolution. Immediate appropriate relief will be granted to you when the outcome is favorable to you. For adverse determinations, the notice will include specific findings related to the care, the policies, and procedures relied upon in making the determination, the Physician's and provider's recommendations, including any recommendations for alternative procedures or services, and a description of the procedures, if any, for reconsideration of the adverse decision.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The request for independent review may be submitted only by an insured, the parent or guardian of an insured who is a minor, or a legal guardian or representative of an insured who is incapacitated. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's right to any other benefits under the Plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply: the cost of the service must be \$500 or more; you must have exhausted the above appeals procedures and remain dissatisfied; the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna; or the proposed treatment is excluded as experimental, and you have a terminal condition with a substantial probability of causing death within two years or impairing your ability to regain or maintain maximum function; the standard treatments have been exhausted and the treating Physician certifies that there is no standard treatment available under this certificate more beneficial than the proposed treatment; the treating Physician has certified in writing the treatment is likely to be more beneficial than any available standard treatment; and the treating Physician has certified in writing that scientifically valid studies demonstrate that the proposed treatment is likely to be more beneficial to you than available standard treatment. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must complete the written request form and forward it to the Georgia state planning agency. The planning agency will select an Independent Review Organization to review the issue and the Independent Review Organization will make a determination that is binding upon Cigna.

The Independent Review Organization will render an opinion within 15 working days following receipt of all necessary information. When requested and when a delay would be detrimental to your condition, as determined by the treating health care provider, the review shall be completed within 72 hours of receipt of all necessary information.

The Independent Review Program is a voluntary program arranged by Cigna.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific Plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your Plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.



Legal Action

If your Plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna in federal court until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services or within three years after proof of claim is required under the Plan for Out-of-Network services.

Assistance from the State of Georgia

You have the right to contact the Department of Insurance or the Department of Human Resources for assistance at any time. The Department of Insurance or the Department of Human Resources may be contacted at the following respective addresses and telephone numbers:

Georgia Department of Insurance
2 Martin Luther King, Jr. Drive
Floyd Memorial Bldg, 704 West Tower
Atlanta, GA 30334
404-656-2056

Georgia Dept. of Human Resources
Two Peachtree Street, NW
Suite 33.250
Atlanta, GA 30303-3167
404-657-5550

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

CERTIFICATE RIDER – Illinois Residents

Rider Eligibility: Each Employee who is located in Illinois

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Illinois group insurance plans covering insureds located in Illinois. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

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The Schedule

If your medical plan is subject to a Lifetime Maximum or Preventive Care Maximum, The Schedule is amended to indicate that Mammogram charges do not accumulate towards those maximums. In addition, In-Network Preventive Care Related (i.e. “routine”) Mammograms will be covered at “No charge”.

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Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient, except for 48/96 hour maternity stays;
- for Mental Health Residential Treatment Services.

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Covered Expenses

- charges for ambulatory surgical facilities and associated anesthesia charges for dental care that is provided to a covered individual who: is a child age 6 or under; has a medical condition that requires hospitalization or general anesthesia for dental care; or is disabled.
- charges made, and anesthetics provided by a dentist with a permit by the IL Department of Financial and Professional Regulation to administer general anesthesia, deep sedation, or conscious sedation in conjunction with dental care that is provided to an insured in a dental office, oral surgeon's office, Hospital or ambulatory surgical treatment center if the individual is under age 26 and has been diagnosed with an Autism Spectrum Disorder or a Developmental

Disability and has made 2 visits to the dental care provider prior to accessing this coverage.

A person who is disabled refers to a person, regardless of age, with a chronic disability if the chronic disability meets all of the following conditions:

- it is attributable to a mental or physical impairment or a combination of such impairments; and
- it is likely to continue; and
- it results in substantial functional limitations in one or more of the following areas of major life activity: self-care; receptive and expressive language, learning; mobility; capacity for independent living; or economic self-sufficiency.

Autism Spectrum Disorders means as defined in Section 10 of the Autism Spectrum Disorders Reporting Act.

Developmental Disability means a disability that is attributable to an intellectual disability or a related condition, if the related condition meets all of the following conditions:

- it is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
 - it is manifested before the individual reaches age 22;
 - it is likely to continue indefinitely; and
 - it results in substantial functional limitations in 3 or more of the following areas of major life activity: self-care, language, learning, mobility, self-direction, and capacity for independent living.
- charges made for or in connection with low-dose mammography screening including breast tomosynthesis for detecting the presence of breast cancer. Coverage shall include: a baseline mammogram for women ages 35 to 39; an annual mammogram for women age 40 and older; and mammograms at intervals considered Medically Necessary for women less than age 40 who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors. Coverage also includes a comprehensive ultrasound screening and MRI of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches as well as a screening MRI when Medically Necessary as determined by a Physician licensed to practice medicine in all of its branches.

- low dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device and image receptor, with radiation exposure delivery of less than one rad per breast for two views of an average sized breast. This term also includes digital mammography and includes breast tomosynthesis. The term "breast tomosynthesis" means a radiologic procedure that involves the acquisition of projection images over the stationary breast to produce cross-sectional digital three-dimensional images of the breast.
- charges made for complete and thorough clinical breast exams performed by a Physician licensed to practice medicine in all its branches, an advanced practice nurse who has a collaborative agreement with a collaborating Physician that authorizes breast examinations, or a Physician assistant who has been delegated authority to provide breast examinations. Coverage shall include such an exam at least once every three years for women ages 20 to 40; and annually for women 40 years of age or older.
- charges for treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, including, but not limited to the use of intravenous immunoglobulin therapy.
- charges made for Medically Necessary acute treatment services and Medically Necessary clinical stabilization services. The treating provider shall base all treatment recommendations and Cigna will base all Medically Necessary determinations for Substance Use Disorders in accordance with the most current edition of the American Society of Addiction Medicine Patient Placement Criteria.

Acute Treatment Services means 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

Clinical stabilization services means 24-hour treatment, usually following acute treatment services for substance use disorder, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

Donated Breast Milk

If the covered person is an infant under the age of 6 months, and a licensed medical practitioner prescribes the milk for the covered person, and all of the following conditions are met:

- the milk is obtained from a human milk bank that meets quality guidelines established by the Human Milk Banking

Association of North America or is licensed by the Department of Public Health;

- the infant's mother is medically or physically unable to produce maternal breast milk or produce maternal breast milk in sufficient quantities to meet the infant's needs or the maternal breast milk is contraindicated;
- the milk has been determined to be Medically Necessary for the infant; and
- one or more of the following applies:
 - the infant's birth weight is below 1,500 grams;
 - the infant has a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis;
 - the infant has infant hypoglycemia;
 - the infant has congenital heart disease;
 - the infant has had or will have an organ transplant;
 - the infant has sepsis;
 - the infant has any other serious congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the infant;
- one or more of the following applies:
 - the child has spinal muscular atrophy;
 - the child's birth weight was below 1,500 grams and he or she has long-term feeding or gastrointestinal complications related to prematurity;
 - the child has had or will have an organ transplant; or
 - the child has a congenital or acquired condition for which the use of donated human breast milk is Medically Necessary and supports the treatment and recovery of the child.

Long-term Antibiotic Therapy

Coverage for long-term antibiotic therapy, including necessary office visits and ongoing testing, for a person with a tick-borne disease when determined to be Medically Necessary and ordered by a Physician licensed to practice medicine in all its branches after making a thorough evaluation of the person's symptoms, diagnostic test results, or response to treatment. An experimental drug must be covered as a long-term antibiotic therapy if it is approved for an indication by the United States Food and Drug Administration. A drug, including an experimental drug, shall be covered for an off-label use in the treatment of a tick-borne disease if the drug has been approved by the United States Food and Drug Administration.

Skin Cancer Screening

Coverage for one annual office visit for a whole body skin examination for lesions suspicious for skin cancer. Screening is not subject to plan cost share.

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Prescription Drug Benefits

Covered Expenses

Prescription Drug List Exceptions

Cigna maintains a medical exceptions process which allows for the request of any clinically appropriate Prescription Drug Product when the:

- drug is not covered based on the plan's Prescription Drug List;
- plan is discontinuing coverage of the drug on the plan's Prescription Drug List for reasons other than safety or other than because the Prescription Drug Product has been withdrawn from the market by the drug's manufacturer;
- prescription drug alternatives required to be used in accordance with a step therapy requirement has been ineffective in the treatment of your disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics, and the known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance or has caused or, based on sound medical evidence, is likely to cause an adverse reaction or harm to you or your Dependent; or
- number of doses available under a dose restriction for the Prescription Drug Product has been ineffective in the treatment of your disease or medical condition or based on both sound clinical evidence and medical and scientific evidence, the known relevant physical and mental characteristics, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

Such medical exceptions procedures require, at a minimum, the following:

- any request for approval of coverage made verbally or in writing (regardless of whether made using a paper or electronic form or some other writing) at any time shall be reviewed by appropriate health care professionals;
- within 72 hours after receipt of a request either approve or deny the request. In the case of a denial, Cigna shall provide you or your authorized representative and your Physician

with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial;

- an expedited coverage determination request must either be approved or denied within 24 hours after receipt of the request. In the case of a denial, Cigna shall provide you or your authorized representative and your Physician with the reason for the denial, an alternative covered medication, submitting an appeal to the denial.

Should your request for an exception be denied, you may refer to the “When You Have a Complaint or Appeal” section of this certificate which outlines the process to request that the original external exception request and the subsequent denial of that request be reviewed by an independent review organization.

A step therapy requirement exception request shall be approved if the: required Prescription Drug Product is contraindicated; you have tried the required Prescription Drug Product while under your current or previous health insurance or health benefit plan and the prescribing Physician submits evidence of failure or intolerance; or you are stable on a Prescription Drug Product selected by your Physician for the medical condition under consideration while on a current or previous health insurance or health benefit plan.

Once the exception request has been approved, the authorization for the coverage for the drug prescribed by your treating Physician, to the extent the prescribed drug is a covered drug under the plan up to the quantity covered and be made for 12 months following the approval or until renewal of the plan.

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

CERTIFICATE RIDER – Indiana Residents

Rider Eligibility: Each Employee who is located in Indiana

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Indiana group insurance plans covering insureds located in Indiana. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

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Prescription Drug Benefits

Limitations

Prescription Eye Drops

Refill of prescription eye drops will be allowed when:

- for a 30 day supply, a request for a refill not earlier than 25 days after the date the prescription eye drops were last dispensed;
- for a 90 day supply, a request for a refill not earlier than 75 days after the date the prescription eye drops were last dispensed;
- the prescribing practitioner has indicated on the prescription that the prescription eye drops are refillable and the refill requested does not exceed the refillable amount remaining on the prescription.

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Prescription Drug Benefits

Exclusions

- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or

Injury, unless coverage for such product(s) is required by federal or state law.

- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.

HC-PHR294

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

CERTIFICATE RIDER – Maine Residents

Rider Eligibility: Each Employee who is located in Maine

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Maine group insurance plans covering insureds located in Maine. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETMERDR

Short-Term Rehabilitative Therapy and Chiropractic Care Services

- charges made for Short-term Rehabilitative Therapy that is part of a rehabilitative program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Also included are services that are provided by a chiropractic Physician when provided in an outpatient setting. Services of a chiropractic Physician include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment

that is rendered to restore motion, reduce pain and improve function.

The following limitation applies to Short-term Rehabilitative Therapy and Chiropractic Care Services:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Short-term Rehabilitative Therapy and Chiropractic Care services that are not covered include but are not limited to:

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional articulation disorder such as correction of tongue thrust, lisp, or verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrences or to maintain the patient's current status.

The following are specifically excluded from Chiropractic Care Services:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- vitamin therapy.

If multiple outpatient services are provided on the same day they constitute one day.

The following applies to Network and Network Point of Service plans, and to Preferred Provider, Exclusive Provider and Open Access Provider copay plans:

A separate Copayment will apply to the services provided by each provider.

HC-COV112

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Medical Conversion Privilege

The provision in your certificate, if any, entitled "Medical Conversion Privilege" will not apply to Maine residents.

HC-CNV

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

CERTIFICATE RIDER – Maryland Residents

Rider Eligibility: Each Employee who is located in Maryland

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Maryland group insurance plans covering insureds located in Maryland. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETMDRDR

The Schedule

The Medical Schedule is amended to remove any of the following OB/GYN notes if included:

Note: OB/GYN provider is considered a Specialist.

Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.

Note: Well-Woman OB/GYN visits will be considered a Specialist visit.

Note: Well-Woman OB/GYN visits will be considered either a PCP or Specialist depending on how the provider contracts with the Insurance Company.

The “**Outpatient Facility Services**” entry in the Medical Schedule is amended to read as follows:

Outpatient Facility Services

Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room and when provided instead of an inpatient service, when an attending physician’s request for an inpatient admission has been denied.

The Medical Schedule is amended to include the following note in the “Delivery – Facility” provision of the “**Maternity Care Services**” section:

Note: Benefit levels will be the same as the benefit levels for Inpatient Hospital Facility Services for any other covered Sickness.

The Medical Schedule is amended to include the following provision, covered at “No charge”, in the “**Maternity Care Services**” section:

Home Visits, as required by law and as recommended by the Physician

SCHEDMD-ET3

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

CERTIFICATE RIDER – Massachusetts Residents

Rider Eligibility: Each Employee who is located in Massachusetts

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Massachusetts group insurance plans covering insureds located in Massachusetts. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETMARDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

Any Dependent child including the newborn infant of a Dependent, an adopted child or foster 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.

HC-ELG12

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Covered Expenses

Covered Expenses include expenses incurred at any of the Approximate Intervals shown below for a Dependent child who is age 5 or less for charges made for Child Preventive Care Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

- a history; physical examination; development assessment; anticipatory guidance; and appropriate immunizations and laboratory tests;
- measurements; sensory screening; neuropsychiatric evaluation; hereditary and metabolic screening at birth; TB test; hematocrit; other appropriate blood tests and urinalysis; special medical formulas approved by the Commissioner of Public Health, prescribed by a Physician, and Medically Necessary for treatment of PKU, tyrosinemia, homocystinuria, maple syrup urine disease, and propionic acidemia or methylmalonic acidemia in infants and children or Medically Necessary to protect the unborn fetuses of pregnant women with PKU.

Excluding any charges for:

- more than one visit to one provider for Child Preventive Care Services at each of the Approximate Intervals up to a total of 12 visits for each Dependent child;
- services for which benefits are otherwise provided under this medical benefits section; and
- services for which benefits are not payable according to the Expenses Not Covered section.

Approximate Intervals are:

- six times during the first year of life;
- three times during the second year of life; and
- annually each year thereafter through the fifth year of life.

Covered Expenses also include expenses incurred for Dependent children from birth until the child's third birthday for Early Intervention Services, up to the Medically Necessary Early Intervention Services Maximum shown in The Schedule, to include: occupational, physical and speech therapy, nursing care and psychological counseling.

These services must be delivered by certified early intervention specialists, as defined by the early intervention operational standards by the Massachusetts Department of

Public Health and in accordance with applicable certification requirements.

- charges made for or in connection with mammograms for breast cancer screening, not to exceed: one baseline mammogram for women age 35 but less than 40, and a mammogram annually for women age 40 and over.
- charges made for screening for lead poisoning of a Dependent child from birth until 6 years of age.
- charges for treatment of an Injury or Sickness of an eligible newborn or adopted child, including the necessary care and treatment of medically-diagnosed congenital defects and birth abnormalities or premature birth.
- charges for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section for a mother and her newborn child. Any decision to shorten such minimum coverage will be made in accordance with rules and regulations promulgated by the Massachusetts Department of Public Health relative to early discharge (less than 48 hours for a vaginal delivery and 96 hours for a caesarean delivery) and post-delivery care, including but not limited to: home visits; parent education; assistance and training in breast or bottle feeding; and the performance of any necessary and appropriate clinical tests. The first home visit may be conducted by a registered nurse, Physician or certified nurse-midwife. Any subsequent home visit determined to be clinically necessary must be provided by a licensed health care provider.
- charges made for cardiac rehabilitation, according to standards developed by the Massachusetts Department of Public Health. Cardiac rehabilitation means a multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease, provided in either a Hospital or other setting and meeting standards set forth by the Massachusetts Commissioner of Public Health.

HC-COV929

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Short-Term Rehabilitative Therapy and Chiropractic Care Services

- charges made for Short-term Rehabilitative Therapy that is part of a rehabilitative program, including physical, speech, occupational, cognitive, osteopathic manipulative, and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Also included are services that are provided by a chiropractic Physician when provided in an outpatient setting. Services of a chiropractic Physician include the conservative management of acute neuromusculoskeletal conditions through manipulation and

ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

The following limitation applies to Short-term Rehabilitative Therapy and Chiropractic Care Services:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Short-term Rehabilitative Therapy and Chiropractic Care services that are not covered include but are not limited to:

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrences or to maintain the patient's current status.

The following are specifically excluded from Chiropractic Care Services:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- vitamin therapy.

If your plan is subject to Copayments, a separate Copayment will apply to the services provided by each provider.

- a child born to one of your Dependent children, as long as your grandchild is living with you and: your Dependent child is insured; or your grandchild is primarily supported by you.

HC-DFS968

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

CERTIFICATE RIDER – Michigan Residents

Rider Eligibility: Each Employee who is located in Michigan

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Michigan group insurance plans covering insureds located in Michigan. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-COV86

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HC-ETMIRDR

Definitions

Dependent

A child includes:

- a legally adopted child. Coverage for an adopted child will begin: on the date of the filing of a petition to adopt such a child, provided the child has been residing in your home as a foster child, and for whom you have been receiving foster care payments; or when a child has been placed in your home by a licensed placement agency for purposes of adoption;

Exclusions, Expenses Not Covered and General Limitations

- 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, except the coverage under this plan is primary to a Michigan automobile no-fault insurance policy issued to a Michigan resident if that automobile policy coordinates with or states that it is secondary to group health insurance.

HC-EXC373

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Expenses For Which A Third Party May Be Responsible

- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault insurance or similar coverage, except the coverage under this plan is primary to a Michigan automobile no-fault insurance policy issued to a Michigan resident if that insurance policy coordinates or states that it is secondary to group health insurance.

HC-SUB124

01-20
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Missouri Residents

Rider Eligibility: Each Employee who is located in Missouri

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Missouri group insurance plans covering insureds located in Missouri. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETMORDR

Missouri First Steps Program

Cigna participates in Missouri's Part C Early Intervention System, "First Steps." "First Steps" provides coverage for Early Intervention Services described in this section that are

delivered by early intervention specialists who are health care professionals licensed by the state of Missouri and acting within the scope of their professions for children from birth to age three identified by the Part C Early Intervention System as eligible services for persons under Part C of the Individuals with Disabilities Education Act.

Early Intervention Services means Medically Necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology devices for children from birth to age three who are identified by the Part C Early Intervention System as eligible for services under Part C of the Individuals with Disabilities Education Act and shall include services under an active individualized family service plan that enhances functional ability without effecting a cure. An individualized family service plan is a written plan for providing early intervention services to an eligible child and the child's family that is adopted in accordance with 20 U.S.C. Section 1436.

Important Information About Your Medical Plan

Direct Access for OB/GYN Services

Female insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for covered OB/GYN services. There is no requirement to obtain an authorization of care from your Primary Care Physician (if you have selected one) for visits to the Participating Provider of your choice for those services defined by the published recommendations of the accreditation council for graduate medical education for training an obstetrician, gynecologist or obstetrician/gynecologist, including but not limited to diagnosis, treatment and referral for such services.

Direct Access for Chiropractic Care Services

Insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for In-Network covered Chiropractic Care services. There is no requirement to obtain an authorization of care from your Primary Care Physician (if you have selected one) for visits to the Participating Provider of your choice for Chiropractic Care.

Covered Expenses

- charges made by a Hospital or an Ambulatory Surgical Facility for anesthesia for inpatient Hospital dental procedures for: a child under the age of five; a person with a severe disability; or a person with a behavioral or medical condition that requires hospitalization or general anesthesia when dental care is provided. Cigna may require prior authorization for hospitalization for dental procedures.

- charges for immunizations (including the associated office visit) for children from birth to age 5 will include poliomyelitis, rubella, rubeola, mumps, tetanus, pertussis, diphtheria, hepatitis B, Haemophilus influenzae type b (Hib), and varicella. This includes the office visit in connection with immunizations. There will be no deductible and no copay.
- charges for or in connection with the diagnosis, treatment and appropriate management of osteoporosis for persons with a condition or medical history for which bone mass measurement is Medically Necessary, provided such services are received by a Physician licensed to practice medicine and surgery in Missouri.
- charges for a colorectal examination and laboratory tests for cancer in accordance with current American Cancer Society guidelines for any nonsymptomatic person covered under the Plan.
- charges for a pelvic examination and Pap smear in accordance with current American Cancer Society guidelines for any nonsymptomatic woman covered under the Plan.
- charges for telehealth (telemedicine) will be covered on the same basis as covered services provided through a face to face consultation or contact with participating provider. Coverage does not include telehealth site origination fees or costs for the provision of telehealth services. Utilization may be utilized to determine the appropriateness of telehealth as a means of delivering a health care service on the same basis as when the same services is delivered in person.
- charges for prostate cancer examinations and laboratory tests for any insured nonsymptomatic male, in accordance with current American Cancer Society guidelines. Men age 50 and older should discuss getting an annual PSA blood test and a digital rectal exam with their Physician. Men who are at risk, which includes African American or men who have a family history of prostate cancer, should consider being tested at a younger age.
- charges made by a Hospital or other facility that provides obstetrical care for inpatient Hospital services will include Covered Expenses for a mother and her newborn child for 48 hours following a vaginal delivery or for 96 hours following a cesarean delivery. A longer stay will be covered if deemed Medically Necessary. The mother may request an earlier discharge if, after consulting with her Physician, it is determined that less time is needed for recovery. If discharged early, at least 2 post discharge visits will be covered, one of which will be a home visit by either a registered nurse with experience in maternal and child health nursing or a Physician. These visits will include, but are not limited to, a physical assessment of the mother and the newborn; parent education; assistance and training in

breast and bottle feeding; education and services for complete childhood immunizations; Medically Necessary clinical tests; and the submission of a metabolic specimen to the state laboratory.

Autism Spectrum Disorder and Applied Behavior Analysis

Coverage is provided for the diagnosis and treatment of autism spectrum disorders, and care prescribed or ordered for a Member diagnosed with an autism spectrum disorder by a licensed Physician or licensed psychologist, including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician's or licensed psychologist's license, including but not limited to: psychiatric care; psychological care; habilitative or rehabilitative care, including behavior analysis therapy; therapeutic care; and pharmacy care. Coverage cannot be denied on the basis that it is educational or habilitative in nature.

The terms used above are defined as follows:

- **Autism spectrum disorders** means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- **Diagnosis of autism spectrum disorders** means Medically Necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder.
- **Treatment for autism spectrum disorders** means care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed Physician or licensed psychologist, including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician's or licensed psychologist's license, including, but not limited to: psychiatric care; psychological care; habilitative or rehabilitative care, including applied behavior analysis therapy; therapeutic care; and pharmacy care.
- **Autism service provider** means any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst.
- **Applied behavior analysis** means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human

behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.

- **Habilitative or rehabilitative care** is professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual.
- **Line therapist** means an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.
- **Pharmacy care** means medications used to address symptoms of an autism spectrum disorder prescribed by a licensed Physician, and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications, only to the extent that such medications are included in the insured's health benefit plan.
- **Psychiatric care** means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- **Psychological care** means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
- **Therapeutic care** means services provided by licensed speech therapists, occupational therapists, or physical therapists.

Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure, as well as charges for the refilling of an eye drop prescription prior to the last day of the prescribed dosage period without regard to a coverage restriction for early refill of prescription renewals provided the prescribing Physician authorizes such early refill.

Prescription Drug Benefits

Exclusions

- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;

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

CERTIFICATE RIDER – Nebraska Residents

Rider Eligibility: Each Employee who is located in Nebraska

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Nebraska group insurance plans covering insureds located in Nebraska. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNERDR

Covered Expenses

- charges made for one screening test for hearing loss for a Dependent child from birth through 31 days old.

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- 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.

HC-EXC340

01-19
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The provisions set forth in this rider comply with the legal requirements of New Hampshire group insurance plans covering insureds located in New Hampshire. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNHRDR

Definitions

Emergency Services

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a Medical Condition. An Emergency Medical Condition means a medical or behavioral condition, the onset of which is sudden, and manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy; serious impairment to such person's bodily functions; serious impairment of any bodily organ or part of such person; or serious disfigurement of such person.

HC-DFS321

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

CERTIFICATE RIDER – New Hampshire Residents

Rider Eligibility: Each Employee who is located in New Hampshire

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

Continuation of Coverage Under New Hampshire State Law

High Risk Pool

If you or your Dependents have been covered for 60 days, you or your Dependent may apply to the New Hampshire High Risk Pool within 31 days after termination of coverage, without having to provide evidence of insurability.

HC-TRM45

04-10
VI-ET1

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

CERTIFICATE RIDER – New Jersey Residents

Rider Eligibility: Each Employee who is located in New Jersey

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of New Jersey group insurance plans covering insureds located in New Jersey. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNJRDR

Payment of Benefits

Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

HC-POB108

01-17
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Definitions

Dependent

Dependents include:

- your lawful spouse or civil union partner; or
- any child of yours who is:
 - less than 26 years old.
 - 26 years old, but less than 26, not married nor in a civil union partnership nor in a Domestic Partnership, enrolled in school as a full-time student and primarily supported by you.
 - 26 or more years old, not married nor in a civil union partnership nor in a Domestic Partnership, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this plan, or while covered as a Dependent under a prior plan with no break in coverage.

Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild. If your civil union partner has a child, that child will also be included as a Dependent.

HC-DFS978

01-17
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – New Mexico Residents

Rider Eligibility: Each Employee who is located in New Mexico

You will become insured on the date you become eligible, include if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of New Mexico group insurance plans covering insureds located in New Mexico. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Consumer Complaint Notice

If you are a resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding a claim, premium, or other matters relating to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:

<https://www.osi.state.nm.us/ConsumerAssistance/index.aspx>.

HC-ETNMRDRV3

When You Have a Complaint or an Appeal (Grievance)

For the purposes of this section, any reference to "you," "your" or "Member" also refers to Grievant.

Information about Appeals (Grievance) Procedures

Cigna is responsible for:

- including a clear and concise description of all grievance procedures, both internal and external, in boldface type in the enrollment materials, including in member handbooks or evidence of coverage issued to Grievants;
- for a person who has been denied coverage, providing him or her with a copy of the grievance procedures;
- notifying Grievants that a representative of Cigna and the Managed Health Care Bureau of the insurance division are available upon request to assist with grievance procedures by including such information, and a toll-free telephone number for obtaining such assistance, in the enrollment materials and Summary of Benefits issued to Grievants;
- providing a copy of its grievance procedures and all necessary grievance forms at each decision point in the grievance process and immediately upon request, at any time, to a Grievant, Provider, or other interested person;
- providing a detailed written explanation of the appropriate grievance procedures and a copy of the grievance form to a Grievant or Provider when Cigna makes either an Adverse Determination or adverse administrative decision. The written explanation will describe how Cigna reviews and resolves grievances and provide a toll-free number, facsimile number, e-mail address, and mailing address of Cigna's consumer assistance office;
- providing consumer education brochures and materials developed and approved by the Superintendent, annually, or as directed by the Superintendent in consultation with Cigna for distribution;
- providing notice to enrollees in a Culturally and Linguistically Appropriate Manner;
- providing continued coverage for an ongoing course of treatment pending the outcome of an internal appeal;
- not reducing or terminating an ongoing course of treatment without first notifying the Grievant sufficiently in advance of the reduction or termination to allow the Grievant to appeal and obtain a determination on review of the proposed reduction or termination;
- allowing individuals in Urgent Care situations and receiving an ongoing course of treatment to proceed with an expedited external review at the same time as the internal review process.

Timeframes for Initial Utilization Management Determinations

For initial Utilization Management Determinations, we will respond in writing with a decision within 5 working days. If more time or information is needed to make the determination, and the delay is due to a reasonable cause beyond our control, and does not result in increased medical risk to you we will notify you in writing as to the reason for the delay, and to request an extension of up to 10 working days. If there is a delay, you will be provided a written progress report within the original five (5) working day review period.

You may request, either verbally or in writing, that the initial determination be expedited, and we will make a determination within 24 hours after receiving your request, if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function; or your Physician makes a reasonable request; or it is the opinion of your Physician, who has knowledge of your medical condition, that you would be subject to severe pain that cannot be adequately managed without the care or treatment in question; or the medical exigencies of your case require an expedited determination; or your claim involves Urgent Care.

When considering whether to certify a Health Care Service requested by a Provider or Grievant, Cigna will determine whether the requested Health Care Service is covered by the Health Benefits Plan. Before denying a Health Care Service requested by a Provider or Grievant on grounds of a lack of coverage, Cigna will determine that there is no provision of the Health Benefits Plan under which the requested Health Care Service could be covered. If Cigna finds that the requested Health Care Service is not covered by the Health Benefits Plan, Cigna need not address the issue of Medical Necessity.

If Cigna finds that the requested Health Care Service is covered by the Health Benefits Plan, then when considering whether to certify a Health Care Service requested by a Provider or Grievant, a Physician, registered nurse, or other Health Care Professional shall, within the timeframe required by the medical exigencies of the case, determine whether the requested Health Care Service is Medically Necessary.

Before Cigna denies a Health Care Service requested by a Provider or Grievant on grounds of a lack of Medical Necessity, a Physician shall render an opinion as to Medical Necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of Uniform Standards used by Cigna. The Physician shall be under the clinical authority of the medical director responsible for Health Care Services provided to Grievants.

Notice of Initial Utilization Management Determination

You and your Provider will be notified within two (2) working days of the date a Health Care Service has been certified, unless earlier notice is required due to the medical exigencies of your case.

You will be notified by telephone, or as required by the medical exigencies of your case, no later than twenty-four hours after an Adverse Determination decision has been made, followed by a written or electronic communication within one (1) working day of the telephone notice, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered under the plan. If you fail to provide such information, you will be afforded a reasonable amount of time, but not less than forty-eight (48) hours to provide the specified information.

If the Adverse Determination is based on Medical Necessity, the notice will include a clear and complete explanation as to why the requested service is not Medically Necessary. If the Adverse Determination is based on lack of coverage, the notice will identify all plan provisions relied upon, and include a clear and complete explanation as to why the requested service is not covered by the plan provisions. A statement that the requested Health Care Service is not covered under the Health Benefits Plan will not be sufficient. The notice will include the date of service, the health care Provider, the claim amount (if applicable) and a statement describing the availability (upon request) of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. It will also include a description of the Cigna standard that was used in denying the claim and provide a summary of the discussion which triggered the final determination. The notice will also advise you of your rights to request an internal or external review of the Adverse Determination. Appeals procedures and any required forms will be sent along with the notice.

Customer Service

We want you to be completely satisfied with the care you receive. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a Rescission of Coverage, you may call our toll-free number 1-888-992-4462 and explain your concern to one of our Customer Service representatives.

When You Have a Complaint or an Appeal (Grievance)

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure, without being subject to retaliation for any reason related to the appeal.

You must submit a request for an appeal in writing. If you need help completing the forms required to initiate an internal review, we will assist you. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number 1-888-992-4462 or write to:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

The New Mexico Managed Health Care Bureau is also available for assistance:

Office of Superintendent of Insurance
Managed Health Care Bureau
Post Office Box 1689
Santa Fe, New Mexico 87504-1689
E-mail: mhcb.grievance@state.nm.us
Phone: 1-855-427-5674
Fax: (505) 827-3833
Website: <http://www.osi.state.nm.us/managed-healthcare/contact-us.html>.

Once we receive your appeal, we will determine whether it is an Adverse Determination appeal, or an administrative appeal.

If your appeal involves both an administrative appeal and an Adverse Determination appeal, we will initiate separate complaints, which will be explained to you in one acknowledgement letter.

Under federal law, you are allowed up to four (4) months after the date of receipt of a notice of Adverse Determination or final Adverse Determination to file a request for external review.

Adverse Determination Appeal

An Adverse Determination means any of the following: any Rescission of Coverage (whether or not a rescission has any adverse effect on any particular benefit at the time); a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

An Adverse Determination Appeal means an oral or written complaint submitted by or on behalf of a Grievant regarding an Adverse Determination.

We will review your appeal in accordance with the procedures for Adverse Determination Appeals outlined below and as required by 13.10.17.17 NMAC through 13.10.17.22 NMAC. The Adverse Determination Appeals procedures include an internal appeal, an appeal to Cigna, an internal panel review, and an external appeal.

Administrative Appeal

If the appeal is not based on an Adverse Determination of a pre- or post- Health Care Service, it is an Administrative Appeal.

An Administrative Appeal means an oral or written complaint submitted by or on behalf of a Grievant regarding any aspect of a Health Benefits Plan other than a request for Health Care Services, including but not limited to:

- administrative practices of Cigna that affects the availability, delivery, or quality of Health Care Services;
- claims payment, handling or reimbursement for Health Care Services; and
- Terminations of Coverage; including Rescissions of Coverage.

Administrative appeals procedures will be reviewed in accordance with the procedures outlined below in the section, “Administrative Appeal (Grievance) Procedures” and as required by 13.10.17.33 NMAC through 13.10.17.36 NMAC.

Internal Appeal of an Adverse Determination

You have the right to request an internal review (appeal) of an Adverse Determination if you are dissatisfied.

Upon receipt of a request for internal review of an Adverse Determination, Cigna will date and time stamp the request and, within one (1) working day from receipt, send you an acknowledgment that the request has been received. The acknowledgment will contain the name, address, and direct telephone number of a Cigna representative who may be contacted regarding the appeal.

To ensure that you receive a full and fair internal review, we will allow you to review the claim file and present evidence and testimony as part of the internal claims and appeals process, and we will provide you, free of charge, with any new or additional evidence, and any new or additional rationale, considered, relied upon, or generated by Cigna, as soon as possible and sufficiently in advance of the date of the notice of final internal adverse benefit determination to allow you a reasonable opportunity to respond before the final internal Adverse Determination is made.

We will ensure that all internal claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions in such a way that decisions regarding hiring, compensation, termination, promotion, or other similar matters

with respect to any individual (such as a claims adjudicator or medical expert), must not be made based upon the likelihood that the individual will support the denial of benefits.

We will complete your Internal Appeal of an Adverse Determination and if utilized, your Internal Panel Appeal of Adverse Determination within 20 working days after we receive a request for an internal review for a required preservice, or concurrent care coverage determination (decision) that is not expedited. We will respond within 40 working days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, and the delay is due to a reasonable cause beyond our control, and does not result in increased medical risk to you, we will notify you in writing as to the reason for the delay, and to request an extension of up to 10 working days for pre-service claims, and 20 working days for post service claims. If there is a delay, you will be provided a written progress report within the original thirty (30) day review period for pre-service and concurrent appeals; or the sixty (60) day review period for post service appeals.

We will expedite your appeal if appropriate based on the medical exigencies of your case and make a decision no later than seventy-two (72) hours from the time your appeal is received, whenever: the standard time frames under this process would seriously jeopardize the life, health or ability to regain maximum function of the Grievant; the Provider reasonably requests an expedited decision; in the opinion of the Physician with knowledge of the Grievant’s medical condition, would subject the Grievant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim; or the medical exigencies of the case require an expedited decision.

If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

If we fail to comply with the appeal deadlines outlined above, the requested Health Care Service will be deemed approved, unless you, after being informed of your rights, have agreed in writing to extend the deadline.

Adverse Determination Appeal

Cigna will complete the review of the Adverse Determination within the timeframes required by the medical exigencies of your case.

If the initial Adverse Determination was based on a lack of coverage, Cigna will review the Health Benefits Plan and determine whether there is any provision in the plan under which the requested Health Care Service could be certified.

If the initial Adverse Determination was based on a lack of Medical Necessity, Cigna will render an opinion as to Medical Necessity, either after consultation with specialists who are

experts in the area that is the subject of review, or after application of Uniform Standards used by Cigna.

If Cigna reverses the initial Adverse Determination and certifies the service, we will notify you within the timeframes discussed above.

If Cigna upholds the initial Adverse Determination to deny the requested Health Care Service, within the timeframes discussed above, we will notify you, and ascertain if you wish to pursue an Internal Panel Appeal.

If you do not want to appeal further, we will mail you written notification of our decision, along with confirmation of your decision within three (3) working days of our decision.

If we are unable to contact you by phone within seventy-two hours of making the decision to uphold the determination, we will notify you by mail of our decision, along with a self-addressed stamped response form with a box for checking “yes”, and a box for checking “no”, which you may use to indicate whether or not you want to appeal further. If you do not return the response form within 10 working days, we will again attempt to contact you by phone.

If you respond via telephone or response form, that you do wish to appeal further, we will select a medical panel to further review your Adverse Determination.

If you do not respond by telephone; or return the response form:

- for expedited reviews, we will select a medical panel to further review your Adverse Determination.

If you do not make an immediate decision to pursue the appeal, or you have requested additional time to supply supporting documents or information, or postponement, the required timeframe outlined above will be extended to include the additional time you require.

Internal Panel Appeal of Adverse Determination

If we uphold the initial Adverse Determination to deny the requested Health Care Service, we will notify you of your right to an internal panel review (appeal) within the timeframes described in the internal appeal of an Adverse Determination section.

If you choose to pursue the appeal, we will notify you of the date, time, and place of the internal panel review. If Cigna will be represented by an attorney, the notice will advise you that you may want to also seek legal representation.

We will select one or more of Cigna’s representatives and one or more health care or other professionals who have not been previously involved in the Adverse Determination being reviewed to serve on the internal panel. At least one of the Health Care Professionals selected shall practice in a specialty that would typically manage the case that is the subject of the appeal, unless we mutually agree otherwise.

The internal review panel shall review the Health Benefits Plan and determine whether there is any provision in the plan under which the requested Health Care Service could be certified.

The internal review panel shall render an opinion as to Medical Necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of Uniform Standards used by Cigna.

No fewer than three (3) working days prior to the internal panel review, we will provide you copies of:

- pertinent medical records;
- the treating Provider’s recommendation;
- Health Benefits Plan;
- Cigna’s notice of Adverse Determination;
- Uniform Standards relevant to your medical condition that is used by the internal panel in reviewing the Adverse Determination;
- questions sent to or reports received from any medical consultants retained by Cigna; and
- all other evidence or documentation relevant to reviewing the Adverse Determination, including any new or additional rationale considered by Cigna.

We will not unreasonably deny your request for postponement of the internal panel review. The timeframes for internal panel review will be extended during the period of any postponement.

You have the right to:

- attend and participate in the internal panel review;
- present your case to the internal panel;
- submit supporting material both before and at the internal panel review;
- ask questions of any of Cigna’s representatives;
- ask questions of any Health Care Professionals on the internal panel;
- be assisted or represented by a person of your choice, including legal representation; and
- hire a specialist to participate in the internal review panel review at your own expense, but such specialist may not participate in making the decision.

The internal panel will complete its review of the Adverse Determination as required by the medical exigencies of your case and within the timeframes described in the internal appeal of an Adverse Determination section. Internal review panel members must be present physically or by video or telephone conferencing to hear the appeal. An internal review panel member who is not present to hear the grievance either

physically or by video or telephone conferencing cannot participate in the decision.

In an expedited review, we will transmit required information to you using the most expeditious method available.

If an expedited review is conducted during a patient's Hospital stay or course of treatment, Health Care Services shall be continued without cost (except for applicable co-payments and deductibles) to the Grievant until Cigna makes a final decision and notifies you of that decision.

Cigna will not conduct an expedited review of an Adverse Determination made after Health Care Services have been provided to a Grievant.

Within the time period allotted for completion of its internal review, we will notify you of the internal panel's decision by telephone within twenty-four (24) hours of the panel's decision and in writing or by electronic means within one (1) working day of the telephone notice.

The written notice will contain:

- information sufficient for you to identify the claim;
- the names, titles, and qualifying credentials of the persons on the internal review panel;
- a statement of the internal panel's understanding of the nature of the appeal and all pertinent facts;
- a description of the evidence relied on by the internal review panel in reaching its decision;
- a clear and complete explanation of the rationale for the internal review panel's decision;
- every provision of your Health Benefits Plan relevant to the issue of coverage in the case under review, and an explanation as to why each provision did or did not support the panel's decision regarding coverage of the requested Health Care Service;
- the notice shall cite the Uniform Standards relevant to your medical condition and explain whether each supported or did not support the panel's decision regarding the Medical Necessity of the requested Health Care Service;
- notice of your right to request an external review by the Superintendent, including the address and telephone number of the Managed Health Care Bureau of the insurance division, a description of all procedures and time deadlines necessary to pursue external review, and copies of any forms required to initiate external review;
- information about the New Mexico Managed Health Care Bureau available to assist you in the appeal process.

External Review of Adverse Determination Procedure

If you are dissatisfied with the results of an internal panel review, you may request, at no cost to you, an external review by the Superintendent. There is no minimum claim dollar

amount that must be met before you exercise this right to external review.

The Superintendent may require that you exhaust any of Cigna's appeals procedures, as appropriate, before accepting a request for external review.

If exhaustion of internal appeals is required prior to external review, exhaustion will be unnecessary and the internal appeals process will be deemed exhausted if: Cigna waives the exhaustion requirement; or if we are considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or you simultaneously request an expedited internal appeal and an expedited external review.

An exception to the exhaustion requirement is as follows. The internal claims and appeals process will not be deemed exhausted based on violations of Cigna that are minor and do not cause, and are not likely to cause prejudice or harm to you, so long as Cigna demonstrates that the violation was for good cause or due to matters beyond its control, and the violation occurred in the context of an ongoing, good faith exchange of information between Cigna and you, the Grievant, unless the violation is part of a pattern or practice of violations by Cigna.

You may request a written explanation of the violation by Cigna and we will provide it within ten (10) days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or court rejects your request for immediate review on the basis that Cigna met the standards for an exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable amount of time, not to exceed ten (10) days, Cigna will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin to run upon your receipt of such notice.

If required by the medical exigencies of your case, you may telephonically request an expedited review by calling the Managed Health Care Bureau at 1-855-427-5674.

In all other cases, to initiate an external review, you must file a written request for external review with the Superintendent within one hundred and twenty (120) calendar days from receipt of the written notice of internal review decision unless extended by the Superintendent for good cause shown, or unless a longer time frame is permitted under federal law.

Cigna will bear the cost of the external review.

The request shall be:

- mailed to the Office of Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, New Mexico Public Regulation Commission, Post Office Box 1689, Santa Fe, New Mexico 87504-1689; or

- e-mailed to mhcb.grievance@state.nm.us, subject External Review Request; or
- faxed to the Office of Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, at (505) 827-3833; or
- completed on-line with a NM PRC, Division of Insurance Complaint Form available at <http://www.osi.state.nm.us/managed-healthcare/contact-us.html>.

You must file the request for external review on the forms provided by Cigna, and you must also file:

- a copy of the notice of internal review decision;
- a fully executed release form authorizing the Superintendent to obtain any necessary medical records from Cigna or any other relevant Provider; and
- if the appeal involves an experimental or investigational treatment Adverse Determination, the Provider's Certification and recommendation.

You may also file any other supporting documents or information you wish to submit to the Superintendent for review.

If you wish to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review shall be extended up to 90 days from the receipt of the complaint form, or until you submit all supporting documents, whichever occurs first.

Upon receipt of a request for external review, the Superintendent will immediately send:

- you an acknowledgment that the request has been received;
- Cigna a copy of the request for external review.

Upon receipt of the copy of the request for external review, Cigna will, within five (5) working days for standard review or the time limit set by the Superintendent for expedited review, provide to you and the Superintendent, by any available expeditious method:

- the Summary of Benefits;
- the complete Health Benefits Plan, which may be in the form of a member handbook/evidence of coverage;
- all pertinent medical records, internal review decisions and rationales, consulting Physician reports, and documents and information submitted by you or Cigna;
- Uniform Standards relevant to your medical condition that were used by the internal panel in reviewing the Adverse Determination; and
- any other documents, records, and information relevant to the Adverse Determination and the internal review decision or intended to be relied on at the external review hearing.

If Cigna fails to comply with the requirements of this section, the Superintendent may reverse the Adverse Determination. The Superintendent may waive the requirements of this section if necessitated by the medical exigencies of the case.

The Superintendent shall conduct either a standard or expedited external review of the Adverse Determination, as required by the medical exigencies of the case.

The Superintendent shall complete an external review as required by the medical exigencies of the case but in no case later than seventy-two (72) hours of receipt of the external review request whenever:

- the Grievant's life would be jeopardized; or
- the Grievant's ability to regain maximum function would be jeopardized.

If the Superintendent's initial decision is made orally, written notice of the decision must be provided within forty-eight (48) hours of the oral notification.

The Superintendent shall conduct a standard review in all cases not requiring expedited review. Insurance division staff shall complete the initial review within ten (10) working days from receipt of the request for external review and the information required by you and Cigna. If a hearing is held, the Superintendent will complete the external review within forty-five (45) working days from receipt of the complete request for external review. The Superintendent may extend the external review period for up to an additional ten (10) working days when the Superintendent has been unable to schedule the hearing within the required timeframe and the delay will not result in increased medical risk to the Covered Person.

Upon receipt of the request for external review, insurance division staff shall review the request to determine whether:

- you have provided the documents required;
- the individual is or was insured by Cigna at the time the Health Care Service was requested or provided;
- the Grievant has exhausted Cigna's internal review procedure and any applicable appeal review procedure; and
- the Health Care Service that is the subject of the appeal reasonably appears to be a covered benefit under the Health Benefits Plan.

If the request is for external review of an experimental or investigational treatment Adverse Determination, insurance division staff shall also consider whether the recommended or requested Health Care Service:

- reasonably appears to be a covered benefit under the Grievant's Health Benefit Plan except for Cigna's determination that the Health Care Service is experimental or investigational for a particular medical condition; and

- is not explicitly listed as an excluded benefit under the Grievant's Health Benefit Plan; and the Grievant's treating Provider has certified that:
 - standard Health Care Services have not been effective in improving the Grievant's condition; or
 - standard Health Care Services are not medically appropriate for the Grievant; or
 - there is no standard Health Care Service covered by Cigna that is as beneficial or more beneficial than the Health Care Service:
 - recommended by the Grievant's treating Provider that the treating Provider certifies in writing is likely to be more beneficial to the Grievant, in the treating Provider's opinion, than standard Health Care Services; or
 - requested by the Grievant regarding which the Grievant's treating Provider, who is a licensed, board certified or board eligible Physician qualified to practice in the area of medicine appropriate to treat the Grievant's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the Health Care Service requested by the Grievant is likely to be more beneficial to the Grievant than available standard Health Care Services.

If the request for external review is incomplete, insurance division staff will immediately notify you and Cigna and require that you submit the required information within the specified period of time.

If the request for external review does not meet the prescribed criteria and, if applicable, insurance division staff will so inform the Superintendent. The Superintendent will notify you and Cigna that the request does not meet the criteria for external review and is thereby denied, and that you have the right to request a hearing within thirty-three (33) days from the date the notice was mailed.

If the request for external review is complete and meets the required criteria and, if applicable, insurance division staff shall so inform the Superintendent. The Superintendent shall notify you and Cigna that the request meets the criteria for external review and that an informal hearing has been set to determine whether, as a result of Cigna's Adverse Determination, you were deprived of Medically Necessary covered services. Prior to the hearing, insurance division staff shall attempt to informally resolve the appeal.

The notice of hearing shall be mailed no later than eight (8) working days prior to the hearing date. The notice shall state the date, time, and place of the hearing and the matters to be considered and shall advise the Grievant and Cigna of the rights. The Superintendent shall not unreasonably deny a request for postponement of the hearing made by you or Cigna.

The Superintendent may designate a Hearing Officer who shall be an attorney licensed to practice in New Mexico. The hearing may be conducted by telephone conference call, video conferencing, or other appropriate technology at the insurance division's expense.

The Superintendent may designate two (2) Independent Co-Hearing Officers (ICOs) who must be licensed Health Care Professionals and who must maintain independence and impartiality in the process. If the Superintendent designates two (2) ICOs, at least one of them shall practice in a specialty that would typically manage the case that is the subject of the appeal.

The Superintendent or attorney Hearing Officer shall regulate the proceedings and perform all acts and take all measures necessary or proper for the efficient conduct of the hearing. The Superintendent or attorney Hearing Officer may:

- require the production of additional records, documents, and writings relevant to the subject of the appeal;
- exclude any irrelevant, immaterial, or unduly repetitious evidence; and
- if you or Cigna fails to appear, proceed with the hearing or adjourn the proceedings to a future date, giving notice of the adjournment to the absent party.

Staff may attend the hearing, ask questions, and otherwise solicit evidence from the parties, but shall not be present during deliberations among the Superintendent or his designated Hearing Officer and any ICOs.

Testimony at the hearing shall be taken under oath. The Superintendent or Hearing Officers may call and examine you, Cigna, and other witnesses.

The hearing shall be stenographically recorded at the insurance division's expense.

Both you and Cigna have the right to:

- attend the hearing; Cigna shall designate a person to attend on its behalf and you may designate a person to attend on your behalf if you choose not to attend personally;
- be assisted or represented by an attorney or other person; and
- call, examine and cross-examine witnesses; and
- submit to the ICO, prior to the scheduled hearing, in writing, additional information that the ICO must consider when conducting the internal review hearing and require that the information be submitted to Cigna and the MHCB staff.

You and Cigna must each stipulate on the record that the Hearing Officers shall be released from civil liability for all communications, findings, opinions, and conclusions made in the course and scope of the external review. The Superintendent shall consult with appropriate professional

societies, organizations, or associations to identify licensed health care and other professionals who are willing to serve as ICOs in external reviews.

The Superintendent will provide for maintenance of a list of licensed professionals qualified to serve as Independent Co-Hearing Officers. The Superintendent will select appropriate professional societies, organizations or associations to identify licensed health care and other professionals willing to serve as Independent Co-Hearing Officers in external reviews who maintain independent and impartiality of the process.

Prior to accepting designation as an ICO, each potential ICO shall provide to the Superintendent a list identifying all Health Care Insurers and Providers with whom the potential ICO maintains any health care related or other professional business arrangements and briefly describe the nature of each arrangement. Each potential ICO shall disclose to the Superintendent any other potential conflict of interest that may arise in hearing a particular case, including any personal or professional relationship to the Grievant or Cigna or Providers involved in a particular external review.

The Superintendent shall consult with appropriate professional societies, organizations, or associations in New Mexico to determine reasonable compensation for health care and other professionals who are appointed as ICOs for external appeal reviews and shall annually publish a schedule of ICO compensation in a bulletin.

Upon completion of an external review, the attorney and ICO shall each complete a statement of ICO compensation form prescribed by the Superintendent detailing the amount of time spent participating in the external review and submit it to the Superintendent for approval. The Superintendent shall send the approved statement of ICO compensation to Cigna. Within thirty (30) days of receipt of the statement of ICO compensation, Cigna will remit the approved compensation directly to the ICO.

If the parties provide written notice of a settlement up to three (3) working days prior to the date set for external review hearing, compensation will be unavailable to the Hearing Officers or ICOs.

The Hearing Officer and ICOs must maintain written records for a period of three (3) years and make them available upon request.

At the close of the hearing, the Hearing Officers shall review and consider the entire record and prepare findings of fact, conclusions of law, and a recommended decision. Any Hearing Officer may submit a supplementary or dissenting opinion to the recommended decision.

Within the time period allotted for external review, the Superintendent shall issue an appropriate order. If the order requires action by Cigna, the order shall specify the timeframe for compliance.

The order shall be binding on you and Cigna and shall state that you and Cigna have the right to judicial review and that state and federal law may provide other remedies.

Neither you nor Cigna may file a subsequent request for external review of the same Adverse Determination that was the subject of the Superintendent's order.

Administrative Appeal (Grievance) Procedures

If you are dissatisfied with a decision, action or inaction by Cigna, including Termination of Coverage, you have the right to request an internal review of an administrative appeal orally or in writing.

Within three (3) working days after receipt of an administrative appeal, we will send you a written acknowledgment that we have received the administrative appeal. The acknowledgment shall contain the name, address, and direct telephone number of a Cigna representative you may contact regarding the administrative appeal.

Cigna will promptly review the administrative appeal. The initial review will:

- be conducted by a Cigna representative authorized to take corrective action on the administrative appeal; and
- allow you to present any information pertinent to the administrative appeal.

Cigna will mail a written decision to you within fifteen (15) calendar days after we receive an appeal for a required preservice administrative appeal. Cigna will mail a written decision to you within fifteen (15) working days of receipt of the postservice administrative appeal. The fifteen (15) day period may be extended when there is a delay in obtaining documents or records necessary for the review of the administrative appeal, provided we notify you in writing of the need and reasons for the extension and the expected date of resolution, or by our mutual written agreement.

The written decision shall contain:

- information sufficient for you to identify the claim;
- the name, title, and qualifications of the person conducting the initial review;
- a statement of the reviewer's understanding of the nature of the administrative appeal and all pertinent facts;
- a clear and complete explanation of the rationale for the reviewer's decision;
- identification of the Health Benefits Plan provisions relied upon in reaching the decision;
- reference to evidence or documentation considered by the reviewer in making the decision;
- a statement that the initial decision will be binding unless you submit a request for reconsideration within twenty (20) working days of receipt of the initial decision;

- a description of the procedures and deadlines for requesting reconsideration of the initial decision, including any necessary forms; and
- information about the New Mexico Managed Health Care Bureau available to assist you in the appeal process.

Upon receipt of a request for reconsideration, we appoint a reconsideration committee consisting of one or more Cigna employees who have not participated in the initial decision. We may include one or more employees other than the Grievant to participate on the reconsideration committee.

The reconsideration committee shall schedule and hold a hearing within fifteen (15) calendar days after receiving a request for a reconsideration of a preservice administrative appeal, and within fifteen (15) working days after receipt of a request for reconsideration of a postservice administrative appeal. The hearing shall be held during regular business hours at a location reasonably accessible to you, and we will offer you the opportunity to communicate with the committee, at our expense, by conference call, video conferencing, or other appropriate technology. We will not unreasonably deny any request you make for postponement of the hearing. If Cigna will be represented by an attorney, the notice will advise you that you may want to also seek legal representation.

We will notify you in writing of the hearing date, time and place at least ten (10) working days in advance. The notice shall advise you of your rights.

No fewer than three (3) working days prior to the hearing, we will provide you all documents and information that the committee will rely on in reviewing the case.

You have the right to:

- attend the reconsideration committee hearing;
- present your case to the reconsideration committee;
- submit supporting material both before and at the reconsideration committee hearing;
- ask questions of any Cigna representative; and
- be assisted or represented by a person of your choice.

We will mail a written decision to you within seven (7) working days after the reconsideration committee hearing. The written decision shall include:

- information sufficient for you to identify the claim;
- the names, titles, and qualifications of the persons on the reconsideration committee;
- the reconsideration committee's statement of the issues involved in the administrative appeal;
- a clear and complete explanation of the rationale for the reconsideration committee's decision;

- the Health Benefits Plan provision relied on in reaching the decision;
- references to the evidence or documentation relied on in reaching the decision;
- a statement that the initial decision will be binding unless you submit a request for external review by the Superintendent within twenty (20) working days of receipt of the reconsideration decision; and
- a description of the procedures and deadlines for requesting external review by the Superintendent, including any necessary forms.

The notice will also contain the toll free telephone number and address of the Superintendent's office.

External Review of Administrative Appeal by Superintendent

If you are dissatisfied with the results of the internal review of an administrative decision you have the right to request external review by the Superintendent. The Superintendent may require that you exhaust any of Cigna's appeal procedures before accepting an administrative appeal for external review.

If exhaustion of internal appeals is required prior to external review, exhaustion will be unnecessary and the internal appeals process will be deemed exhausted if: Cigna waives the exhaustion requirement; or if we are considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or you simultaneously request an expedited internal appeal and an expedited external review.

An exception to the exhaustion requirement is as follows. The internal claims and appeals process will not be deemed exhausted based on violations of Cigna that are minor and do not cause, and are not likely to cause prejudice or harm to you, so long as Cigna demonstrates that the violation was for good cause or due to matters beyond its control, and the violation occurred in the context of an ongoing, good faith exchange of information between Cigna and you, the Grievant, unless the violation is part of a pattern or practice of violations by Cigna.

You may request a written explanation of the violation by Cigna and we will provide it within ten (10) days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or court rejects your request for immediate review on the basis that Cigna met the standards for an exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable amount of time, not to exceed ten (10) days, Cigna will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim will begin to run upon your receipt of such notice.

To initiate an external review, you must file a written request for external review with the Superintendent within twenty (20) working days from receipt of the written notice of reconsideration decision.

The request shall either be:

- mailed to the Office of Superintendent of Insurance, Attn: Managed Health Care Bureau – External Review Request, New Mexico Public Regulation Commission, Post Office Box 1689, Santa Fe, New Mexico 87504-1689; or
- e-mailed to mhcb.grievance@state.nm.us, subject External Review Request; or
- faxed to the Office of Superintendent of Insurance, Attn: Managed Health Care Bureau - External Review Request, (505) 827-3833; or
- completed on-line using a NM PRC, Division of Insurance Complaint Form available at <http://www.osi.state.nm.us/managed-healthcare/contact-us.html>.

You must file the request for external review on the forms Cigna provides to you. You may also file any other supporting documents or information you wish to submit to the Superintendent for review. If you wish to supply supporting documents or information subsequent to the filing of the request for external review, the timeframes for external review will be extended up to 90 days from the receipt of the complaint form, or until you submit all supporting documents, whichever occurs first.

Upon receipt of a request for external review, the Superintendent will immediately send:

- you an acknowledgment that the request has been received;
- Cigna a copy of the request for external review.

Upon receipt of the copy of the request for external review, Cigna will provide you and the Superintendent, by any available expeditious method within five (5) working days all necessary documents and information considered in arriving at the administrative appeal decision.

The Superintendent shall review the documents submitted by you or Cigna, and may conduct an investigation or inquiry or consult with you, as appropriate. The Superintendent shall issue a written decision on the administrative appeal within twenty (20) working days of receipt of the complete request for external review.

Confidentiality

Health Care Insurers, the Superintendent, Independent Co-Hearing Officers, and all others who acquire access to identifiable medical records and information of Grievants when reviewing grievances shall treat and maintain such records and information as confidential except as otherwise provided by federal and New Mexico law.

HC-APL105

05-12
V3-ET

Definitions

Certification

The term Certification means a decision by Cigna that a Health Care Service requested by a Provider or Grievant has been reviewed and, based upon the information available, meets Cigna's requirements for coverage and Medical Necessity, and the requested Health Care Service is therefore approved.

HC-DFS476V2

05-12
ET

Covered Person

The term Covered Person means a policyholder, subscriber, enrollee, or other individual entitled to receive health care benefits provided by a Health Benefits Plan, and includes Medicaid recipients enrolled in a Health Care Insurer's Medicaid plan and individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act.

HC-DFS478

04-10
V2-ET

Culturally and Linguistically Appropriate Manner of Notice

The term Culturally and Linguistically Appropriate Manner of Notice means:

- A grievance related notice that meets the following requirements:
 - oral language services provided by Cigna (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and

appeals (including external review) in any applicable non-English language;

- a grievance related notice provided by Cigna, upon request, in any applicable non-English language;
- included in the English versions of all grievance related notices provided by Cigna, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by Cigna; and
- for purposes of this definition, with respect to an address in any New Mexico county to which a grievance related notice is sent, a non-English language is an applicable non-English language if ten percent (10%) or more of the population residing in the county is literate only in the same non-English language, as determined by the department of health and human services (HHS); the counties that meet this ten percent (10%) standard, as determined by HHS, are found at <http://cciio.cms.gov/resources/factsheets/clas-data.html> and any necessary changes to this list are posted by HHS annually.

HC-DFS609

05-12
ET

Grievant

The term Grievant means any of the following:

- A policyholder, subscriber, enrollee, or other individual, or that person’s authorized representative or provider, acting on behalf of that person with that person’s consent, entitled to receive health care benefits provided by Cigna;
- An individual, or that person’s authorized representative, who may be entitled to receive health care benefits provided by Cigna;
- Medicaid recipients enrolled in a Cigna Medicaid plan, if Cigna offers such a plan.

If Cigna purchases or is authorized to purchase health care coverage pursuant to the New Mexico Health Care Purchasing Act, a Grievant includes individuals whose health insurance coverage is provided by such coverage.

HC-DFS477V2

05-12
ET

Health Benefits Plan

The term Health Benefit Plan means a health plan or a policy, contract, certificate or agreement offered or issued by a Health Care Insurer or plan administrator to provide, deliver, arrange

for, pay for, or reimburse the costs of Health Care Services; this includes a Traditional Fee-For-Service Health Benefits Plan.

HC-DFS479V2

05-12
ET

Health Care Insurer

The term Health Care Insurer means a person that has a valid certificate of authority in good standing issued pursuant to the Insurance Code to act as an insurer, health maintenance organization, nonprofit health care plan, fraternal benefit society, vision plan, or pre-paid dental plan.

HC-DFS480

04-10
V2-ET

Health Care Professional

The term Health Care Professional means a Physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide Health Care Services consistent with state law.

HC-DFS488

04-10
V2-ET

Health Care Services

The term Health Care Services means services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease, and includes, to the extent offered by the Health Benefits Plan, physical and mental health services, including community-based mental health services, and services for developmental disability or developmental delay.

HC-DFS481

04-10
V2-ET

Hearing Officer, Independent Co-Hearing Officer or ICO

The terms Hearing Officer, Independent Co-Hearing Officer or ICO mean a health care or other professional licensed to practice medicine or another profession who is willing to assist the superintendent as a Hearing Officer in understanding and analyzing Medical Necessity and coverage issues that arise in external review hearings.

HC-DFS482 04-10
V2-ET

Medical Necessity or Medically Necessary

The terms Medical Necessity or Medically Necessary mean Health Care Services determined by a Provider, in consultation with the Health Care Insurer, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by the Health Care Insurer consistent with such federal, national, and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

HC-DFS483 04-10
V2-ET

Provider

The term Provider means a duly licensed Hospital or other licensed facility, Physician, or other Health Care Professional authorized to furnish Health Care Services within the scope of their license.

HC-DFS484 04-10
V2-ET

Rescission of Coverage

The term Rescission of Coverage means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

- the cancellation or discontinuance of coverage has only a prospective effect; or
- the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to

timely pay required premiums or contributions towards the cost of coverage.

HC-DFS608 05-12
ET

Termination of Coverage

The term Termination of Coverage means the cancellation or non-renewal of coverage provided by Cigna to a Grievant but does not include a voluntary termination by a Grievant or termination of a Health Benefits Plan that does not contain a renewal provision.

HC-DFS485V2 05-12
ET

Traditional Fee-For-Service Indemnity Benefit

The term Traditional Fee-For-Service Indemnity Benefit means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage Grievants to utilize preferred Providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

HC-DFS486V2 05-12
ET

Uniform Standards

The term Uniform Standards means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by the Health Care Insurer consistent with the federal, national, and professional practice guidelines that are used by a Health Care Insurer in determining whether to certify or deny a requested Health Care Service.

HC-DFS487 04-10
V2-ET

Utilization Management Determinations

The term Utilization Management Determinations means the outcome, including Certification and adverse determination, of

the review and evaluation of Health Care Services and settings for Medical Necessity, appropriateness, efficacy, and efficiency.

HC-DFS475

04-10
V2-ET

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

CERTIFICATE RIDER – North Carolina Residents

Rider Eligibility: Each Employee who is located in North Carolina

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of North Carolina group insurance plans covering insureds located in North Carolina. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNCRDR

Covered Expenses

- charges made by a Hospital or ambulatory surgical facility for anesthesia and facility charges for services performed in the facility in connection with dental procedures for: Dependent children below age 9; covered persons with serious mental or physical conditions; or covered persons with significant behavioral problems. The treating provider must certify that hospitalization or general anesthesia is required in order to safely and effectively perform the procedure because of the person's age, condition or problem.
- charges made for or in connection with: the treatment of congenital defects and abnormalities, including those charges for your newborn child from the moment of birth; and with the treatment of cleft lip or cleft palate.

- obstetrical and gynecological services that are provided by qualified Providers for care of or related to the female reproductive system and breasts, and for annual screening, counseling and immunizations for disorders and diseases in accordance with the most current recommendations of the American College of Obstetricians and Gynecologists. Gynecological services include coverage for cervical cancer screening and surveillance tests for ovarian cancer.
- charges made for surgical or non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) excluding appliances and orthodontic treatment.

HC-COV936

01-20
ET4

Prescription Drug Benefits

Exclusions

- coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.

More than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies. We will authorize payment for any prescription dispensed under a declared state of emergency or disaster issued by the North Carolina Governor or General Assembly, or by the President of the United States. If the covered person requesting coverage of the refill or replacement of the prescription resides in a county that is covered under a state of emergency or disaster regardless of the date upon which the prescription had most recently been filled by a pharmacist, if all of the following conditions apply:

- The North Carolina Commissioner of Insurance issues a Bulletin Advisory notifying insurance carriers of a declared disaster or state of emergency in North Carolina;
- The covered person requesting coverage of the refill or replacement prescription resides in a county that is covered under the declared disaster or state of emergency; and
- The prescription medication is requested within 29 days after the effective date of the declared disaster or state of emergency as stated the Bulletin Advisory.

The time period for the waiver of prescription medication refills may be extended in 30-day increments by an order issued by the North Carolina Commissioner of Insurance. Cigna will cover the requested medication, in accordance

with the terms of the plan, provided that additional refills still remain on the prescription and are consistent with the orders of the prescriber or the authority of the dispensing pharmacy.

- quantity limitations shall be consistent with the original prescription and the extra or replacement fill may recognize proportionate dosage use prior to the declared disaster or state of emergency.

HC-PHR302

01-19
ET

Definitions

Dependent

A child includes an adopted child or foster child including that child from the first day of placement in your home regardless of whether the adoption has become final.

HC-DFS700

07-14
VI-ET

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

CERTIFICATE RIDER – Ohio Residents

Rider Eligibility: Each Employee who is located in Ohio

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Ohio group insurance plans covering insureds located in Ohio. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETOHRDR

Covered Expenses

- charges made for or in connection with: an annual cytologic screening (Pap smear) for detection of cervical cancer; a single baseline mammogram for women ages 35 to 39; a mammogram every two years for women ages 40 through 49, or an annual mammogram if a licensed Physician has determined the woman to be at risk; and an annual mammogram for women ages 50 through 64.
- charges for any drug approved by the Food and Drug Administration (FDA) which has not been approved by the FDA for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the Department of Health and Human Services (HHS) under 42 U.S.C. 1395x(t)(2), as amended, or in medical literature only if all of the following apply:
 - Two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed;
 - No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed;
 - Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the HHS pursuant to section 1861(t)(2)(B) of the "Social Security Act," 107 Stat. 591 (1993), 42 U.S.C. 1395x(t)(2)(B), as amended, as acceptable peer-reviewed medical literature.

Coverage includes Medically Necessary services associated with the administration of the drug.

Such coverage shall not be construed to do any of the following:

- Require coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
- Require coverage for experimental drugs not approved for any indication by the FDA;
- Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the FDA;

- Require reimbursement or coverage for any drug not included in the drug formulary or list of covered drugs specified in the policy;
- Prohibit Cigna from limiting or excluding coverage of a drug, provided that the decision to limit or exclude coverage of the drug is not based primarily on the coverage of drugs described in this provision.

HC-COV123
HC-COV124

04-10
V1-ET3

Prescription Drug Benefits

Limitations

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card. Your Provider may request a Step Therapy exemption. An exemption request will be granted or denied within 48 hours for a request related to urgent care services and 10 calendar days for all other requests. See your Appeals section of this certificate for your Appeal rights.

Supply Limits

Prescription drug coverage shall provide for medication synchronization for an insured if all of the following conditions are met: (1) the insured elects to participate in medication synchronization; (2) The insured, prescriber, and pharmacist at a Network Pharmacy agree that medication synchronization is in the best interest of the insured; (3) The prescription drug meets the requirements to be eligible for inclusion in medication synchronization.

To be eligible a drug must: (1) Be covered under the plan; (2) Be prescribed for the treatment and management of a chronic disease or condition and be subject to refills; (3) Satisfy all relevant prior authorization criteria; (4) Not have any quantity limits, dose optimization criteria, or other requirements that would be violated if synchronized; (5) Not have an special handling or sourcing needs, as determined by the plan that require a single designated pharmacy to fill or refill the prescription; (6) Be formulated so that the quantity or amount dispensed can be effectively divided in order to achieve synchronization; (7) Not be a schedule II controlled substance, opiate, or benzodiazepine.

A policy or plan shall authorize coverage of a prescription drug subject to medication synchronization when the drug is dispensed in a quantity or amount that is less than a thirty one (31) day supply. Medication synchronization applies only once for each prescription drug subject to medication synchronization for the same insured unless; a) the prescriber changes the dosage or frequency of administration of a prescription drug subject to medication synchronization or; b) the prescriber prescribes a different drug. Shall permit and apply a prorated daily cost-sharing rate for a supply of a prescription drug subject to medication synchronization that is dispensed at a Network Pharmacy. Requirement does not waive any cost sharing in its entirety.

"Medication synchronization" means a pharmacy service that synchronizes the filling or refilling of prescriptions in a manner that allows the dispensed drugs to be obtained on the same date each month.

"Cost-sharing" means the cost to an insured according to any coverage limit, Copayment, Coinsurance, Deductible, or other out-of-pocket expense requirements imposed by the policy or plan.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you may not receive coverage for the Specialty Prescription Drug Product.

HC-PHR345

01-20
ET

Termination of Insurance

Special Continuation of Medical Insurance for Military Reservists and Their Dependents

If you are a Reservist, and if your Medical Insurance would otherwise cease because you are called or ordered to active military duty, you may continue Medical Insurance for yourself and your Dependents, upon payment of the required premium to your Employer, until the earliest of the following dates:

- 18 months from the date your insurance would otherwise cease, except that coverage for a Dependent may be extended to 36 months as provided in the section below entitled “Extension of Continuation to 36 months”;
- the last day for which the required premium has been paid;
- the date you or your Dependent becomes eligible for insurance under another group policy that does not contain any pre-existing condition limitation, other than the Civilian Health and Medical Program of the Uniformed Services;
- the date the group policy is cancelled.

The continuation of Medical Insurance will provide the same benefits as those provided to any similarly situated person insured under the policy who has not been called to active duty.

“Reservist” means a member of a reserve component of the armed forces of the United States. “Reservist” includes a member of the Ohio National Guard and the Ohio Air National Guard.

Extension of Continuation to 36 Months

If your Dependent’s insurance is being continued as outlined above, such Dependent may extend the 18-month continuation to a total of 36 months if any of the following occur during the original 18-month period:

- you die;
- you are divorced or legally separated from your spouse; or
- your Dependent ceases to qualify as an eligible Dependent under the policy.

Provisions Regarding Notification and Election of Special Continuation

Your Employer will notify you of your right to elect continuation of Medical Insurance. To elect the continuation, you or your Dependent must notify the Employer and pay the required premium within 31 days after the date your insurance would otherwise cease, or within 31 days after the date you are notified of your right to continue, if later.

Special Continuation of Medical Insurance

If your Active Service ends because of involuntary termination of employment, and if:

- you have been insured under the policy (or under the policy and any similar group coverage replaced by the policy) during the entire 3 months prior to the date your Active Service ends; and
 - you pay the Employer the required premium;
- your Medical Insurance will be continued until:
- you become eligible for similar group medical benefits or for Medicare;
 - the last day for which you have made the required payment;
 - 12 months from the date your Active Service ends; or
 - the date the policy cancels;
- whichever occurs first.

At the time you are given notice of termination of employment, your Employer will give you written notice of your right to continue the insurance. To elect this option, you must apply in writing and make the required monthly payment to the Employer within 31 days after the date your Active Service ends.

If your insurance is being continued under this section, the Medical Insurance for Dependents insured on the date your insurance would otherwise cease may be continued, subject to the provisions of this section. The insurance for your Dependents will be continued until the earlier of:

- the date your insurance for yourself ceases; or
- with respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent.

This option will not reduce any continuation of insurance otherwise provided.

Dependent Medical Insurance After Divorce

In the case of divorce, annulment, dissolution of marriage or legal separation you may be required to continue the insurance for any one of your Dependents.

Conversion Available After Continuation

The provisions of the “Medical Conversion Privilege” section will apply when the insurance ceases.

When You Have A Complaint Or An Appeal

Definitions

“Adverse benefit determination” means a decision by a health plan issuer:

- To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
 - A determination that the health care service does not meet the health plan issuer’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
 - A determination of an individual’s eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage;
 - A determination that a health care service is not a covered benefit;
 - The imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
- To rescind coverage on a health benefit plan.

“Authorized representative” means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

- A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;
- A person authorized by law to provide substituted consent for a covered individual;
- A family member or a treating health care professional, but only when the covered person is unable to provide consent.

“Covered person” means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan.

“Covered person” does include the covered person’s authorized representative with regard to an internal appeal or external review.

“Covered benefits” or **“benefits”** means those health care services to which a covered person is entitled under the terms of a health benefit plan.

“Final adverse benefit determination” means an adverse benefit determination that is upheld at the completion of a health plan issuer’s internal appeals process.

“Health benefit plan” means a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

“Health care services” means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

“Health plan issuer” means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. **“Health plan issuer”** includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.

“Independent review organization” means an entity that is accredited to conduct independent external reviews of adverse benefit determinations.

“Rescission” or **“to rescind”** means a cancellation or discontinuance of coverage that has a retroactive effect.

“Rescission” does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

“Stabilize” means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person’s medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

In the case of a woman having contractions, **“stabilize”** means such medical treatment as may be necessary to deliver, including the placenta.

“Superintendent” means the superintendent of insurance.

When You Have a Complaint

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Customer Service

We are here to listen and to help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Internal Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing, within 365 days of receipt of a denial notice, to the following address:

Cigna HealthCare, Inc.
National Appeals Unit
P.O. Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision).

We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will

notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

If the appeal involves a coverage decision based on issues of medical necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was not involved in any previous decision related to your appeal, and not a subordinate of previous decision makers. Provide all relevant documentation with your second-level appeal request.

For required preservice and concurrent care coverage determinations, the review will be completed within 15 calendar days. For postservice claims, the review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by us to complete the review.

You will be notified in writing of the decision within five working days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer or your treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Understanding the External Review Process

Under Chapter 3922 of the Ohio Revised Code all health plan issuers must provide a process that allows a person covered under a health benefit plan or a person applying for health benefit plan coverage to request an independent external review of an adverse benefit determination. This is a summary of that external review process. An adverse benefit determination is a decision by Cigna to deny benefits because services are not covered, are excluded, or limited under the plan, or the covered person is not eligible to receive the benefit.

The adverse benefit determination may involve an issue of medical necessity, appropriateness, health care setting, or level of care or effectiveness. An adverse benefit determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The covered person does not pay for the external review. There is no minimum cost of health care services denied in order to qualify for an external review. However, the covered person must generally exhaust the health plan issuer's internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the adverse benefit determination.

External Review by an IRO - A covered person is entitled to an external review by an IRO in the following instances:

- The adverse benefit determination involves a medical judgment or is based on any medical information.
- The adverse benefit determination indicates the requested service is experimental or investigational, the requested health care service is not explicitly excluded in the covered person's health benefit plan, and the treating physician certifies at least one of the following:
 - Standard health care services have not been effective in improving the condition of the covered person.
 - Standard health care services are not medically appropriate for the covered person.
 - No available standard health care service covered by Cigna is more beneficial than the requested health care service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- The covered person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the

covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal.

- The covered person's treating physician certifies that the final adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
- The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not yet been discharged from a facility.
- An expedited internal appeal is already in progress for an adverse benefit determination of experimental or investigational treatment and the covered person's treating physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective final adverse benefit determinations (meaning the health care service has already been provided to the covered person).

External Review by the Ohio Department of Insurance - A covered person is entitled to an external review by the Department in the either of the following instances:

- The adverse benefit determination is based on a contractual issue that does not involve a medical judgment or medical information.
- The adverse benefit determination for an emergency medical condition indicates that medical condition did not meet the definition of emergency AND Cigna's decision has already been upheld through an external review by an IRO.

Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the covered person, or an authorized representative, must request an external review through Cigna within 180 days of the date of the notice of final adverse benefit determination issued by Cigna.

All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally; however written confirmation of the request must be submitted to Cigna no later than five (5) days after the initial request. The covered person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete Cigna will initiate the external review and notify the covered person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the covered person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. Cigna will also forward all documents and information used to make the adverse benefit determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete Cigna will inform the covered person in writing and specify what information is needed to make the request complete. If Cigna determines that the adverse benefit determination is not eligible for external review, Cigna must notify the covered person in writing and provide the covered person with the reason for the denial and inform the covered person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by Cigna and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the health benefit plan and all applicable provisions of the law.

IRO Assignment

When Cigna initiates an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with Cigna, the covered person, the health care provider or the health care facility will not be selected to conduct the review.

IRO Review and Decision

The IRO must consider all documents and information considered by Cigna in making the adverse benefit determination, any information submitted by the covered person and other information such as; the covered person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the health benefit plan, the most appropriate practice guidelines, clinical review criteria used by the health plan issuer or its utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by Cigna of a request for a standard review or

within 72 hours of receipt by Cigna of a request for an expedited review. This notice will be sent to the covered person, Cigna and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review.
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- The dates over which the external review was conducted.
- The date on which the independent review organization's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.

NOTE: Written decisions of an IRO concerning an adverse benefit determination that involves a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

Binding Nature of External Review Decision

An external review decision is binding on Cigna except to the extent Cigna has other remedies available under state law. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law.

A covered person may not file a subsequent request for an external review involving the same adverse benefit determination that was previously reviewed unless new medical or scientific evidence is submitted to Cigna.

If You Have Questions About Your Rights or Need Assistance

You may contact Cigna:

Cigna HealthCare Inc.
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422
1-800-Cigna24
www.Cigna.com



You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

Contact ODI Consumer Affairs:

<https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp>

File a Consumer Complaint:

<http://insurance.ohio.gov/Consumer/OCS/Pages/ConsComp1.aspx>

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse benefit determination, will include: the specific reason or reasons for the adverse benefit determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); and upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse benefit determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; limit. You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or

the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

HC-APL66

HC-APL65

04-10

V1-ET

Definitions

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

CERTIFICATE RIDER – Oklahoma Residents

Rider Eligibility: Each Employee who is located in Oklahoma

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Oklahoma group insurance plans covering insureds located in Oklahoma. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETOKRDR

Covered Expenses

- charges made for or in connection with mammograms for breast cancer screening for a single low-dose mammogram every five years for women ages 35 through 39 and one annually for women age 40 and over, will not be subject to

plan Deductibles, Copayments and Coinsurance. Low Dose Mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast, digital mammography, or Breast Tomosynthesis. Breast Tomosynthesis means a radiologic mammography procedure involving the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which breast cancer screening diagnoses may be made.

HC-COV898

01-20
ET3

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

CERTIFICATE RIDER – Oregon Residents

Rider Eligibility: Each Employee who is located in Oregon

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Oregon group insurance plans covering insureds located in Oregon. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ORM-04-11

HC-ETORRDR

Certification Requirements

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Any PAC determination will be binding on Cigna for:

- the lesser of: 5 business days; or in the event your coverage will terminate sooner than 5 business days, the period your coverage remains in effect, provided that when PAC is authorized:
 - Cigna has specific knowledge that your coverage will terminate sooner than 5 business days; and
 - the termination date is specified in the PAC; or
- the time period your coverage remains in effect, subject to a maximum of 30 calendar days.

For purposes of counting days, day 1 occurs on the first business or calendar day, as applicable, following the day on which Cigna issues a PAC.

Cigna will respond to a PAC request for a non-emergency admission within two business days of the date of the request. Qualified health care personnel will be available for same-day telephone responses to CSR inquiries.

HC-PAC4

11-14
V2-ET

Covered Expenses

- charges made for Medically Necessary medical services, including rehabilitation services, for a Dependent child under 18 years of age who has been diagnosed with a pervasive developmental disorder. "Pervasive developmental disorder" means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability or intellectual disability. "Rehabilitation services" means physical therapy, occupational therapy or speech therapy services to restore or improve function.

HC-COV618

12-17
V1 ET3

When You Have a Complaint or Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted; and "Physician reviewers" are licensed Physicians.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

Customer Services Toll-free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will acknowledge receipt of an appeal within 7 days of its receipt and respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. However, for postservice appeals involving Medical Necessity, we will respond in writing within 20 working days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if: the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain

which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request within 7 days of its receipt and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if: the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. Cigna's Physician reviewer will consult with a Physician reviewer in the same or similar specialty as the care under consideration to make a decision. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

You have the right to apply for external review by an Independent Review Organization if you are not fully

satisfied with the decision of Cigna's level two appeal review regarding your Medical Necessity or clinical appropriateness issue.

The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. **Cigna agrees to be bound by the Independent Review Organization's decision notwithstanding the definition of Medical Necessity in the plan.**

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial by Cigna must be based on a Medical Necessity determination, issues of clinical appropriateness, or whether a course or plan of treatment that an insured is undergoing is an active course of treatment for the purpose of continuity of care. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for an independent review under this process.

To request a review, you must notify the Appeals Coordinator in writing within 180 days of your receipt of Cigna's level two appeal review denial. You must also sign a waiver granting the Independent Review Organization access to your medical records.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by a provider with an established clinical relationship to the insured, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by Cigna.

Appeal to the State of Oregon

You have the right to file a complaint or seek other assistance from the Oregon agency. Assistance is available:

- by calling (503) 947-7984 or the toll free message line at (888) 877-4894;
- by writing to the Oregon agency, Consumer Protection Unit, 350 Winter Street NE, Room 440-2, Salem, OR 97301-3883;
- through the Internet at <http://www.cbs.state.or.us/external/ins/>; or
- by e-mail at: DCBS.INSMAIL@state.or.us

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant

is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which: was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

In most instances, you may not initiate a legal action against Cigna until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

HC-APL4

04-10

VI-ET

Prescription Drug Benefits

Limitations

Prescription Eye Drops

For prescription eye drops, one early refill will be allowed to treat Glaucoma under certain conditions:

- (1) The refill is requested by an insured less than 30 days after the later of:
 - The date the original prescription was dispensed to the insured; or

- The date that the last refill of the prescription was dispensed to the insured.
- (2) The prescriber indicates on the original prescription that a specific number of refills will be needed.
- (3) The refill does not exceed the number of refills that the prescriber indicated under subsection (2) of this section.
- (4) The prescription has not been refilled more than once during the 30-day period prior to the request for an early refill.

HC-PHR246

01-20
VI ET

Definitions

Dependent

The term child means a child born to you or a child legally adopted by you including that child from the date of placement. Coverage for such child will include the necessary care and treatment of medical conditions existing prior to the date of placement including medically diagnosed congenital defects or birth abnormalities. It also includes a stepchild.

HC-DFS1067

10-16
ET1

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

CERTIFICATE RIDER – Pennsylvania Residents

Rider Eligibility: Each Employee who is located in Pennsylvania

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Pennsylvania group insurance plans covering insureds located in Pennsylvania. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETPARDR

Covered Expenses

- charges made for or in connection with mammograms for breast cancer screening and diagnosis, not to exceed: a baseline mammogram annually for women age 40 and over; and a mammogram upon a Physician’s recommendation for women under age 40.
- charges for childhood immunizations, including the immunizing agents and Medically Necessary booster doses. Immunizations provided in accordance with Advisory Committee on Immunization Practices (ACIP) standards are covered for any insured person under age 21 and are exempt from deductibles or dollar limits.

HC-COV571

12-16

HC-COV321

10-15

ET1

Definitions

Dependent

The term child means a child born to you or a child legally adopted by you including that child, from the date of placement in your home, regardless of whether the adoption has become final.

HC-DFS1007

10-16

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

CERTIFICATE RIDER – South Carolina Residents

Rider Eligibility: Each Employee who is located in South Carolina

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of South Carolina group insurance plans covering insureds located in South Carolina. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETSCRDR

Definitions

Dependent

A child includes a legally adopted child, including that child from the first day of placement in your home regardless of whether the adoption has become final, or an adopted child of whom you have custody according to the decree of the court provided you have paid premiums. Adoption proceedings must be instituted by you, and completed within 31 days after the child's birth date, and a decree of adoption must be entered within one year from the start of proceedings, unless extended by court order due to the child's special needs.

HC-DFS273

04-10
VI-ET

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

CERTIFICATE RIDER – South Dakota Residents

Rider Eligibility: Each Employee who is located in South Dakota

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of South Dakota group insurance plans covering insureds located in South Dakota. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETSRRDR

Covered Expenses

Applied Behavioral Analysis

Charges for applied behavior analysis (ABA) for the treatment of autism spectrum disorder, subject to any applicable pre-authorization and licensing requirements.

Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

ABA must be performed by a provider licensed by the Board of Medical and Osteopathic Examiners or the Board of Examiners of Psychologists or have a Master's degree or doctoral degree and be certified by the National Behavior Analyst Certification Board with a designation of board certified behavior analyst. Coverage does not include supervisory services performed by these types of providers.

Cigna, at its own expense, may request a review of the ABA treatment being received, but not more than once every three months, unless Cigna and the ABA provider agree to a more frequent review.

HC-COV699

12-17
ET1

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- 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.

HC-EXC312

01-19
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Tennessee Residents

Rider Eligibility: Each Employee who is located in Tennessee

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Tennessee group insurance plans covering insureds located in Tennessee. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETTNRDR

Covered Expenses

- charges for treatment of conditions or disorders of hearing, speech, voice or language if treatment is received from a licensed audiologist or speech pathologist.

HC-COV927

02-20
ET1

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

CERTIFICATE RIDER – Texas Residents

Rider Eligibility: Each Employee who is located in Texas

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Texas group insurance plans covering insureds located in Texas. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETTNRDR

Important Notice

Notice of Coverage for Acquired Brain Injury

Your health benefit plan coverage for an acquired brain injury includes the following services:

- cognitive rehabilitation therapy;
- cognitive communication therapy;
- neurocognitive therapy and rehabilitation;
- neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment;
- neurofeedback therapy and remediation;
- post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and

- reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute care treatment or services may be obtained in any facility where such services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

The following words and terms shall have the following meanings:

Acquired brain injury - A neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

Cognitive communication therapy - Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive rehabilitation therapy - Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Community reintegration services - Services that facilitate the continuum of care as an affected individual transitions into the community.

Enrollee - A person covered by a health benefit plan.

Health benefit plan - As described in the Insurance Code § 1352.001 and § 1352.002.

Issuer - Those entities identified in the Insurance Code § 1352.001.

Neurobehavioral testing - An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

Neurobehavioral treatment - Interventions that focus on behavior and the variables that control behavior.

Neurocognitive rehabilitation - Services designed to assist cognitively impaired individuals to compensate for deficits in

cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive therapy - Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback therapy - Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological testing - An evaluation of the functions of the nervous system.

Neurophysiological treatment - Interventions that focus on the functions of the nervous system.

Neuropsychological testing - The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological treatment - Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Other similar coverage - The medical/surgical benefits provided under a health benefit plan. This term recognizes a distinction between medical/surgical benefits, which encompass benefits for physical illnesses or injuries, as opposed to benefits for mental/behavioral health under a health benefit plan.

Outpatient day treatment services - Structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

Post-acute care treatment services - Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-acute transition services - Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Psychophysiological testing - An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological treatment - Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Remediation - The process(es) of restoring or improving a specific function.

Services - The work of testing, treatment, and providing therapies to an individual with an acquired brain injury.

Therapy - The scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

Examinations for Detection of Cervical Cancer

Benefits are provided for each covered female age 18 and over for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Benefits include at a minimum: a conventional Pap smear screening; or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224, or write us at the address on the back of your ID card.

Coverage and/or Benefits For Reconstructive Surgery After Mastectomy – Enrollment

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

- all stages of the reconstruction of the breast on which mastectomy has been performed;
- surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
- prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending Physician.

Prohibitions:

We may not:

- offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above;
- condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above;
- reduce or limit the amount paid to the Physician or Provider, nor otherwise penalize, or provide a financial incentive to induce the Physician or Provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224, or write us at the address on the back of your ID card.

Coverage and/or Benefits For Reconstructive Surgery After Mastectomy – Annual

Your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224, or write us at the address on the back of your ID card.

Coverage for Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

- 48 hours following a mastectomy, and
- 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions:

We may not:

- deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours;
- provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours;
- reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or
- provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224, or write us at the address on the back of your ID card.

Coverage for Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

- a physical examination for the detection of prostate cancer; and
- a prostate-specific antigen test for each covered male who is
 - at least 50 years of age; or
 - at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224, or write us at the address on the back of your ID card.

Coverage for Inpatient Stay Following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery, and
- 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Prohibitions:

We may not:

- modify the terms of this coverage based on any covered person requesting less than the minimum coverage required;
- offer the mother financial incentives or other compensation for waiver of the minimum number of hours required;
- refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians;

- reduce payments or reimbursements below the usual and customary rate; or
- penalize a physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224, or write us at the address on the back of your ID card.

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

- a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or
- a colonoscopy performed every 10 years.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224, or write us at the address on the back of your ID card.

HC-IMP211

03-17

ET1

The Schedule

The following sentence is added to the "Hospital Emergency Room" section under the "Emergency and Urgent Care Services" section of **The Schedule** shown in your medical certificate:

Emergency and Urgent Care Services

Hospital Emergency Room

(including a properly licensed freestanding emergency medical care facility)

The Schedule is amended to indicate the following:

Cardiovascular Disease Screening

Charges for Cardiovascular Disease Screenings are payable at 100%, with one screening every 5 years, not to exceed \$200.

The Medical Schedule is amended to indicate that no separate maximum/deductible shall apply to **Diabetic Equipment**.

The **Nutritional Evaluation** annual maximum shown in the Medical Schedule is amended to indicate the following:

"3 visits per person however, the 3 visit limit will not apply to treatment of diabetes."

SCHEDTX-ET

Covered Expenses

- charges made for an annual screening by all forms of low dose mammography for the presence of occult breast cancer for women 35 years of age and older. Coverage will also be provided for a diagnostic mammogram. Diagnostic mammogram means an imaging examination designed to evaluate: a) a subjective or objective abnormality detected by a Physician in a breast; b) an abnormality seen by a Physician on a screening mammogram; c) an abnormality previously identified by a Physician as probably benign in a breast for which follow-up imaging is recommended by a Physician; or d) an individual with a personal history of breast cancer. Low dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, and screens with an average radiation exposure delivery of less than on rad mid-breast and with two views for each breast, digital mammography or breast tomosynthesis. Breast tomosynthesis means a radiologic mammography procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which applicable breast cancer screening diagnoses may be determined.
 - charges made for reconstructive surgery of craniofacial abnormalities for a child who is younger than 18 years of age to improve the function of, or to attempt to create a normal appearance for an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease.
 - charges made for an acquired brain injury including: cognitive rehabilitation therapy; cognitive communication therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment; neurofeedback therapy and remediation; post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.
 - charges made for an annual medically recognized diagnostic examination for the early detection of cervical cancer for each covered female age 18 and over. Such coverage shall include at a minimum: a conventional pap smear screening; or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.
 - charges for a screening test for hearing loss from birth through the date the child is 30 days old, and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.
 - charges for or in connection with a medically recognized screening exam for the detection of colorectal cancer for each insured who is at least 50 years of age and at normal risk for developing colon cancer. Coverage will include: an annual fecal occult blood test; and either a flexible sigmoidoscopy performed every five years; or a colonoscopy performed every 10 years.
 - charges for a drug that has been prescribed for the treatment of a covered chronic, disabling or life-threatening Sickness, provided that drug is Food and Drug Administration approved for at least one indication and is recognized for treatment in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or supported by articles in accepted, peer-reviewed medical literature. Coverage will also be provided for any medical services necessary to administer the drug.
 - charges made for all generally recognized services prescribed in relation to Autism Spectrum Disorder for Dependent children so long as the diagnosis occurred prior to the insured's 10th birthday. Such coverage must include a screening at the ages of 18 and 24 months. Such coverage must be prescribed by a Physician in a treatment plan and shall include evaluation and assessment services; applied behavior analysis; behavior training and behavior management; speech therapy; occupational therapy; physical therapy; or medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder. The individual prescribing such treatment must be a health care practitioner:
 - who is licensed, certified, or registered by an appropriate agency of this state;
 - whose professional credential is recognized and accepted by an appropriate agency of the United States;
 - who is certified as a provider under the TRICARE military health system; or
 - an individual acting under the supervision of a health care practitioner described above.
- Autism Spectrum Disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder--Not Otherwise Specified. Neurobiological disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

- charges for a service provided through Telemedicine or Telehealth are covered.

These benefits may not be subject to a greater Deductible, Copayment, or Coinsurance than for the same service under this plan provided through a face-to-face consultation. Such coverage will not include charges for a Telemedicine medical service or a Telehealth service provided by an audio-only telephone consultation, a text-only e-mail message or a facsimile transmission.

The term Telemedicine medical service is defined as a health care service delivered by a Physician licensed in Texas, or provided by a health professional acting under Physician supervision, and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician using telecommunications or information technology.

The term Telehealth service is defined as a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

- charges for Hospital Confinement of a mother and her newborn child for 48 hours following an uncomplicated vaginal delivery, or for 96 hours following an uncomplicated cesarean delivery. After consulting with her attending Physician the mother may request an earlier discharge if it is determined that less time is needed for recovery. If Medical Necessity requires the mother and/or newborn to remain confined for longer than 48 hours, the additional confinement will be covered. If the mother is discharged prior to the 48 or 96 hours described above, a postpartum home care visit will be covered. Postpartum home care services include parent education; assistance and training in breast feeding and bottle feeding; and the performance of any necessary and appropriate clinical tests.
- charges for administration of newborn screening tests, including for the cost of a newborn screening test kit as dictated by the Department of State Health Services.
- charges for diagnostic and surgical treatment for conditions effecting temporomandibular joint and craniomandibular disorders which are a result of: an accident; trauma; a congenital defect; a developmental defect; or a pathology.
- charges made for or in connection with annual diagnostic examinations for the detection of prostate cancer, regardless of Medical Necessity; and a prostate-specific antigen (PSA) test for a man who is at least 50 years of age and asymptomatic or at least 40 years of age with a family history of prostate cancer, or another prostate risk factor.

- charges for a minimum of 48 hours of inpatient care following a mastectomy and a minimum 24 hours following a lymph node dissection for the treatment of breast cancer. A shorter period of inpatient care may be deemed acceptable if the insured consults with the Physician and both agree it is appropriate.
- charges for immunizations for children from birth through age 5. These immunizations will include: diphtheria; Haemophilus influenzae type B; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella (chicken pox); rotavirus; and any other children's immunizations required by the State Board of Health. A Deductible, Copayment, or Coinsurance is not required for immunizations.
- charges for a medically acceptable bone mass measurement to detect low bone mass and to determine your risk of osteoporosis and fractures associated with osteoporosis.
- charges for complications of pregnancy.

Hearing Aids and Cochlear Implants for Children

Coverage will be provided for Medically Necessary hearing aids and cochlear implants for children 18 years and younger so long as they are Medically Necessary. Such coverage shall include:

- fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of the hearing aids;
- treatment related to hearing aids/cochlear implants, including coverage for habilitation and rehabilitation; and
- external speech processor and controller with necessary replacements every three years (for cochlear implants).

Coverage for hearing aids will be limited to one hearing aid in each ear every three years. Coverage for cochlear implants will be limited to one cochlear implant in each ear with internal replacement (medically or audiotologically necessary).

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Serious Mental Illness

Charges for treatment of Serious Mental Illness at the same rate as for other illnesses. A Serious Mental Illness is defined as: schizophrenia, paranoid and other psychotic disorders, bipolar disorders (hypomanic, manic, depressive, and mixed), major depressive disorder, schizoaffective disorders (bipolar or depressive), obsessive-compulsive disorders, and depression in childhood or adolescence.

Diabetes

The following benefits will apply to insulin and non-insulin dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

Diabetes Equipment and Supplies:

- blood glucose monitors, including those designed to be used by the legally blind;
- test strips specified for use with a corresponding glucose monitor;
- lancets and lancet devices;
- visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
- insulin and insulin analog preparations;
- injection aids, including devices used to assist with insulin injection and needleless systems;
- insulin syringes;
- biohazard disposal containers;
- insulin pumps, both external and implantable, and associated appurtenances which include insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin, and other required disposable supplies;
- repairs and necessary maintenance of insulin pumps (not otherwise provided under warranty) and rental fees for pumps during the repair and maintenance. This shall not exceed the purchase price of a similar replacement pump;
- prescription and non-prescription medications for controlling blood sugar level;
- podiatric appliances, including up to two pair of therapeutic footwear per year, for the prevention of complications associated with diabetes;
- glucagon emergency kits.

If determined as Medically Necessary by a treating Physician, new or improved treatment and monitoring equipment or supplies (approved by the FDA) shall be covered.

The training program for diabetes self-management shall be recognized by the American Diabetes Association and shall be performed by a certified diabetes educator (CDE), a multidisciplinary team coordinated by a CDE (e.g., a dietician, Nurse educator, pharmacist, social worker), or a licensed healthcare professional (e.g., Physician, physician assistant, registered Nurse, registered dietician, pharmacist) determined by his or her licensing board to have recent experience in diabetes clinical and educational issues. All individuals providing training must be certified, licensed or registered to provide appropriate health care services in Texas.

Self-management training shall include the development of an individual plan, created in collaboration with the member that addresses:

- nutrition and weight evaluation;
- medications;
- an exercise regimen;
- glucose and lipid control;
- high risk behaviors;
- frequency of hypoglycemia and hyperglycemia;
- compliance with applicable aspects of self-care;
- follow-up on referrals;
- psychological adjustment;
- general knowledge of diabetes;
- self-management skills;
- referral for a fundoscopic eye exam.

This training shall be provided/covered upon the initial diagnosis of diabetes or, the written order of the practitioner/Physician when a change in symptoms or conditions warrant a change in the self-management regime or, the written order of a practitioner/Physician that periodic or episodic continuing education is needed.

Charges made for routine patient care costs in connection with a phase I, phase II, phase III or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection or treatment of a life threatening disease or condition and is approved by: the Centers for Disease Control and Prevention of the United States Department of Health and Human Services; the National Institutes of Health; the United States Food and Drug Administration; the United States Department of Defense; the United States Department of Veterans Affairs; or an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

Routine patient care costs means the costs of any Medically Necessary health care service for which benefits are provided under a health benefit plan, without regard to whether the enrollee is participating in a clinical trial. Routine patient care costs do not include: the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial; the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial; the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; a cost associated with managing a clinical trial; or the cost of a health care service that is specifically excluded from coverage under a health benefit plan.

HC-COV899

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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 or Crisis Stabilization Unit 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 or crisis stabilization unit.

Coverage for necessary care and treatment in a Mental Health Residential Treatment Center or Crisis Stabilization Unit will be provided as if the care and treatment were provided in a Hospital.

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

Mental Health Residential Treatment Center for Children and Adolescents means a Mental Health Residential Treatment Center, as defined in this section, which specializes in the treatment of children and adolescents.

Psychiatric Day Treatment Facility means a Mental Health Residential Treatment Center that provides Outpatient Mental Health Services, as defined in this section.

HC-COV574

03-17
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Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.

HC-COV662

12-17
ET

The Schedule

The pharmacy Schedule is amended to indicate the following:

Oral Chemotherapy Medication

Prescription oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered at Participating Pharmacies at 100% after deductible, if applicable, and at Non-Participating Pharmacies, the same as the out of network medical cost share for injectable/IV chemotherapy.

SCHEDPHARM-ET

Prescription Drug Benefits

Covered Expenses

Cigna shall offer to each enrollee at the then-current benefit level and until the enrollee's plan renewal date any Prescription Drug Product that was approved or covered under the plan for a medical condition or mental illness, regardless of whether the Prescription Drug Product has been removed from the Prescription Drug List. Cigna may, however, move a Prescription Drug Product to a lower cost-share tier at any time during the plan year.

HC-PHR315

01-19
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Prescription Drug Benefits

Limitations

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from

Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors. Your Physician may also request a renewal of a prior authorization at least 60 days before it expires. If at all possible, Cigna will review and provide a determination before the existing authorization expires, if the request was received before the expiration.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the diagnosis and the Prescription Drug Product. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan orally or by submitting a written request stating why the Prescription Drug Product should be covered.

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You or your prescribing Physician may request an exception to a step therapy protocol applicable to a Prescription Drug Product otherwise covered by the plan. The exception request must document why your Physician believes that the preferred Prescription Drug Product alternative(s) are not clinically appropriate for you to use in treatment. Provided you or your Physician submit sufficient information to Cigna with the exception request, Cigna will respond to the exception request within 72 hours of receipt of the request. If your Physician also expresses a reasonable belief that you require the Prescription Drug Product on an emergent basis, then Cigna will respond to the exception request within 24 hours of receipt. Cigna will assess the documentation provided by your Physician against the terms of the applicable exception criteria, which will be made available to the member or prescriber upon request. If Cigna denies the exception request, it will be considered an "adverse determination," as defined by TIC §1369.0546, and you may appeal the determination. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card. These requirements do not apply to prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions.

Prescription drug coverage shall provide for synchronization of prescription drug refills on at least one occasion per insured per year, provided all of the following conditions are met:

- The prescription drugs are covered by the plan's clinical coverage policy or have been approved by a formulary exceptions process;
- The prescription drugs are maintenance medications as defined by the plan and have available refill quantities at the time of synchronization;
- The medications are not Schedule II, III or IV controlled substances;
- You or your Dependent meet all utilization management criteria to the prescription drugs at the time of synchronization;
- The prescription drugs are of a formulation that can be safely split into short-fill periods to achieve synchronization;
- The prescription drugs do not have special handling or sourcing needs as determined by the plan that require a single, Designated Pharmacy to fill or refill the prescription; and

- You agree to the synchronization.

When necessary to permit synchronization, the plan shall apply a prorated daily cost-sharing rate to any medication dispensed by a Network Pharmacy. No dispensing fees shall be prorated, and all dispensing fees shall be based on the number of prescriptions filled or refilled.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Prescription Eye Drops

Coverage for a refill for prescription eye drops shall be provided if the:

- refill is requested no earlier than the 21st day after a 30 day supply is dispensed, the 42nd day after a 60 day supply is dispensed or the 63rd day after a 90 day supply is dispensed;
- prescribing Physician indicates on the original prescription that additional quantities are needed;
- refill requested does not exceed the number of additional quantities needed;
- refill is dispensed within the prescribed dosage period; and
- prescription eye drops are a covered benefit under the plan.

HC-PHR356

01-19
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Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

After satisfying the plan Deductible, if any, your responsibility for a covered Prescription Drug Product will always be the lowest of:

- the Copayment or Coinsurance for the Prescription Drug Product; or
- the Prescription Drug Charge for the Prescription Drug Product; or
- the Pharmacy's Usual and Customary (U&C) Charge for the Prescription Drug Product.

HC-PHR138

10-16
ET

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- the following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- non-medical counseling 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, driving safety courses.

HC-EXC368

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Termination of Insurance

Special Continuation of Medical Insurance

If Medical Insurance for you or your Dependent would otherwise cease for any reason except due to involuntary termination for cause or due to discontinuance in entirety of the policy or an insured class, coverage may be continued if:

- the person was covered by this policy and/or a prior policy for the three months immediately prior to the date coverage would otherwise cease, and
- the person elects continuation coverage and pays the first monthly premium within 60 days of the later of either the date coverage would otherwise cease or the date required notice is provided.

Coverage will continue until the earliest of the following:

- 6 months after continuation coverage is elected for plans with COBRA and 9 months after continuation coverage is elected for those without;
- the end of the period for which premium is paid;
- the date the policy is discontinued and not replaced;
- the date the person becomes eligible for Medicare; and
- the date the person becomes insured under another similar policy or becomes eligible for coverage under a group plan or a state or federal plan.

Texas – Special Continuation of Dependent Medical Insurance

If your Dependent's Medical Insurance would otherwise cease because of your death or retirement, or because of divorce or annulment, his insurance will be continued upon payment of required premium, if: he has been insured under the policy, or a previous policy sponsored by your Employer, for at least one year prior to the date the insurance would cease; or he is a Dependent child less than one year old. The insurance will be continued until the earliest of:

- three years from the date the insurance would otherwise have ceased;
- the last day for which the required premium has been paid;
- with respect to any one Dependent, the earlier of the dates that Dependent: becomes eligible for similar group coverage; or no longer qualifies as a Dependent for any reason other than your death or retirement or divorce or annulment; or
- the date the policy cancels.

If, on the day before the Effective Date of the policy, medical insurance was being continued for a Dependent under a group medical policy: sponsored by your Employer; and replaced by the policy, his insurance will be continued for the remaining portion of his period of continuation under the policy, as set forth above.

Your Dependent must provide your Employer with written notice of retirement, death, divorce or annulment within 15 days of such event. Your Employer will, upon receiving notice of the death, retirement, divorce or annulment, notify your Dependent of his right to elect continuation as set forth above. Your Dependent may elect in writing such continuation within 60 days after the date the insurance would otherwise cease, by paying the required premium to your Employer.

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Medical Benefits Extension Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury or Sickness, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;

- the date you are covered for medical benefits under another group policy;
- the date you are no longer Totally Disabled;
- 90 days from the date your Medical Benefits cease; or
- 90 days from the date the policy is canceled.

Totally Disabled

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

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

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

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

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When You Have A Complaint Or An Adverse Determination Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

When You Have a Complaint

We are here to listen and help. If you have a complaint regarding a person, a service, the quality of care, a rescission of coverage, or contractual benefits not related to Medical Necessity, you can call our toll-free number and explain your concern to one of our Customer Service representatives. A complaint does not include: a misunderstanding or problem of misinformation that can be promptly resolved by Cigna by clearing up the misunderstanding or supplying the correct information to your satisfaction; or you or your provider's dissatisfaction or disagreement with an adverse determination. You can also express that complaint in writing. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form, or write to us at the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your complaint, we will send you a letter acknowledging the date on which we received your complaint no later than the fifth working day after we receive your complaint. We will respond in writing with a decision 30 calendar days after we receive a complaint for a post service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay.

Cigna's Physician reviewer, or your treating Physician, will decide if an expedited appeal is necessary. When a complaint is expedited, we will respond orally with a decision within the earlier of: 72 hours; or one working day, followed up in writing within 3 calendar days.

If you are not satisfied with the results of a coverage decision, you can start the complaint appeals procedure.

Complaint Appeals Procedure

To initiate an appeal of a complaint resolution decision, you must submit a request for an appeal in writing to the following address:

Cigna
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Your complaint appeal request will be conducted by the Complaint Appeals Committee, which consists of at least three people. Anyone involved in the prior decision, or subordinates of those people, may not vote on the Committee. You may present your situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received your request within five working days after the date we receive your request for a Committee review and schedule a Committee review. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer or your treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within the earlier of: 72 hours; or one working day, followed up in writing within three calendar days.

When You Have an Adverse Determination Appeal

An Adverse Determination is a decision made by Cigna that the health care service(s) furnished or proposed to be furnished to you is (are) not Medically Necessary or clinically appropriate. An Adverse Determination also includes a denial by Cigna of a request to cover a specific prescription drug

prescribed by your Physician. If you are not satisfied with the Adverse Determination, you may appeal the Adverse Determination orally or in writing. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. We will acknowledge the appeal in writing within five working days after we receive the Adverse Determination Appeal request.

Your appeal of an Adverse Determination will be reviewed and the decision made by a health care professional not involved in the initial decision.

We will respond in writing with a decision within 30 calendar days after receiving the Adverse Determination appeal request.

You may request that the Adverse Determination Appeal Process be expedited if it relates to: (a) emergency denials, (b) denials of care for life-threatening conditions, (c) denials of continued stays for hospitalized enrollees; and (d) denial of prescription drugs or intravenous infusions for which the Member is receiving benefits under the Agreement; or (e) step therapy requests.

Cigna's Physician reviewer or your treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within the earlier of: 72 hours; or one working day, followed up in writing within three calendar days.

In addition, your treating Physician may request in writing a specialty review within 10 working days of our written decision. The specialty review will be conducted by a Physician in the same or similar specialty as the care under consideration. The specialty review will be completed and a response sent within 15 working days of the request. Specialty review is voluntary. If the specialty reviewer upholds the initial adverse determination and you remain dissatisfied, you are still eligible to request a review by an Independent Review Organization.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's Adverse Determination appeal process or if you feel your condition is life-threatening, you may request that your appeal be referred to an Independent Review Organization. In addition, your treating Physician may request in writing that Cigna conduct a specialty review. The specialty review request must be made within 10 days of receipt of the Adverse Determination appeal decision letter.

Cigna must complete the specialist review and send a written response within 15 days of its receipt of the request for specialty review. If the specialist upholds the initial Adverse Determination, you are still eligible to request a review by an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the

voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process and the decision to use the process is voluntary. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. You will receive detailed information on how to request an Independent Review and the required forms you will need to complete with every Adverse Determination notice.

The Independent Review Program is a voluntary program arranged by Cigna.

Appeal to the State of Texas

You have the right to contact the Texas Department of Insurance for assistance at any time for either a complaint or an Adverse Determination appeal. The Texas Department of Insurance may be contacted at the following address and telephone number:

Texas Department of Insurance
333 Guadalupe Street
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439

If you are not fully satisfied with the decision of Cigna's internal appeal review you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate an external review. Cigna and your benefit plan will abide by the decision of the IRO.

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the denial decision; reference to the specific plan provisions on which the decision is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA Section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar

criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action Under Federal Law

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. If your Complaint is expedited, there is no need to complete the Complaint Appeal process prior to bringing legal action.

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Definitions

Dependent

Dependents include:

- any child of yours who is:
 - less than 26 years old.
 - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while

the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan.

Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.

The term child means a child born to you; a child legally adopted by you; the child for whom you are the legal guardian; the child who is the subject of a lawsuit for adoption by you; the child who is supported pursuant to a court order imposed on you (including a qualified medical child support order), or your grandchild who is your Dependent for federal income tax purposes at the time of application. It also includes a stepchild.

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

CERTIFICATE RIDER – Washington Residents

Rider Eligibility: Each Employee who is located in Washington

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Washington group insurance plans covering insureds located in Washington. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETWARDR

Notice – Know Your Rights Under the Balance Billing Protection Act

Beginning January 1, 2020, Washington state law protects you from 'surprise billing' or 'balance billing' if you receive emergency care in Washington, Oregon or Idaho, or are treated at an in-network Hospital or outpatient surgical facility in Washington.

What is 'surprise billing' or 'balance billing' and when does it happen?

Under your health plan, you are responsible for certain cost-sharing amounts. This includes copayments, coinsurance, and deductibles. You may have additional costs or be responsible for the entire bill if you see a provider or go to a facility that is not in your plan's provider network.

Some providers and facilities have not signed a contract with your insurer. They are called 'out-of-network' providers or facilities. They can bill you the difference between what your insurer pays and the amount the provider or facility bills. This is called 'surprise billing' or 'balance billing'.

Insurers are required to tell you, via their websites or on request, which providers, Hospitals and facilities are in their networks. Hospitals, surgical facilities and providers must tell you which provider networks they participate in, on their website or on request.

When you CANNOT be balance billed:

Emergency Services – The most you can be billed for Emergency Services is your plan's in-network cost-sharing amount if you receive services at an out-of-network Hospital, or from an out-of-network provider that works in the out-of-network Hospital, in Washington, Oregon or Idaho. The provider and facility cannot balance bill you for Emergency Services.

Certain services at an In-Network Hospital or Outpatient Surgical Facility – When you receive surgery, anesthesia, pathology, radiology, laboratory, or hospitalist services from an out-of-network provider while you are at an in-network Hospital or outpatient surgical facility in Washington, the most you can be billed is your in-network cost-sharing amount. These providers cannot balance bill you.

In situations when balance billing is not allowed, the following protections also apply:

- Your insurer will pay out-of-network providers and facilities directly. You are only responsible for paying your in-network cost-sharing.
- Your insurer must:
 - Base your cost-sharing responsibility on what it would pay an in-network provider or facility for the same or similar service in the same geographic area and show that amount in your explanation of benefits.

- Count any amount you pay for Emergency Services or certain out-of-network services (described above) toward your deductible and out-of-pocket limit.
- Your provider, Hospital, or outpatient surgical facility must refund any amount you overpay within 30 business days.
- A provider, Hospital, or outpatient surgical facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital or facility in any OTHER situation, you may still be balance billed, or you may be responsible for the entire bill.

If you believe you have been wrongly billed, file a complaint with the Washington State Office of the Insurance Commissioner at www.insurance.wa.gov or call 1-800-562-6900.

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Prescription Drug Benefits

Limitations

Medication Synchronization and Emergency Fills Medication

Medication synchronization refers to the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period.

If you or your Dependent requests medication synchronization for a new prescription, your prescription may be filled as follows:

- for less than a one-month supply of the Prescription Drug or Related Supply if synchronization will require more than a fifteen-day supply of the Prescription Drug or Related Supply; or
- for more than a one-month supply of the Prescription Drug or Related Supply if synchronization will require a fifteen-day supply of the Prescription Drug or Related Supply or less.

Upon your request, the prescribing provider or pharmacist shall:

- Determine that filling or refilling the prescription is in your best interest, taking into account the appropriateness of synchronization for the drug being dispensed;
- Inform you that the prescription will be filled to less than the standard refill amount for the purpose of synchronizing your medications; and
- Deny synchronization on the grounds of threat to patient safety or suspected fraud or abuse.

Emergency fill refers to a limited dispensed amount of medication that allows time for the processing of a prior authorization request. If you or your Dependent request an emergency fill, the authorized amount of the emergency fill will be no more than the prescribed amount up to a seven day supply or the minimum packaging size available at the time the emergency fill is dispensed.

Emergency fill only applies to those circumstances where a patient presents at a Participating Pharmacy with an immediate therapeutic need for a prescribed medication that requires a prior authorization. An emergency fill does not necessarily constitute a covered health service under this plan. Determination as to whether the emergency fill is a covered health service under this plan will be made as part of the prior authorization process.

The cost sharing for a Prescription Drug or Related Supply subject to coinsurance that is dispensed for less than the standard refill amount for the purpose Medication Synchronization or emergency fills will be adjusted. The cost sharing for Prescription Drug or Related Supply with a copayment that is dispensed for less than the standard refill amount for the purpose of purpose Medication Synchronization or emergency fills will be adjusted by:

- Dividing the insured's copayment for the drug by the normal day supply for the medication to find the Daily Member Cost.
- Multiply the Daily Insured Cost of the drug by the day supply being used. This is the amount Cigna will use to apply for the copayment.

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