Hamilton County Department of Education

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2022

ETALLM22A
3316472

This document printed in January, 2022 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: Hamilton County Department of Education
Rider Eligibility: Each Employee as noted within this certificate rider
Policy No. or Nos.: 3316472
Effective Date: January 1, 2022

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 Tennessee:

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.

Jill Stadelman

Jill Stadelman, Corporate Secretary

HC-ETRDR

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 10-16
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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-ETCORDR

Definitions

Dependent

Dependents include:

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

HC-DFS910 11-16
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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 04-10
V1-ET

Dependent

Dependents are:

- any child of yours who is:
  - less than 26 years old.
  - you natural child, stepchild, or adopted child;
  - after having reach the limiting age, has been continuously covered under any health plan, and not eligible for coverage under the Medicaid or Medicare program.
  - 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 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.

It also includes a stepchild, a foster child, or a child for whom you are the legal guardian.

HC-DFS828 10-16
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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 01-18
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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 04-10
V1-ET

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. For your Dependents to be insured for these benefits, you must elect the Dependent insurance for yourself no later than 30 days after you become eligible.

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.

HC-ELG326 03-21

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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 coverage for diagnosis and treatment of autism spectrum disorder to include autistic disorder, Asperger's Syndrome and pervasive developmental disorder not otherwise specified, when prescribed by a treating Physician. Treatment includes well-baby and well-child screening for diagnosis and treatment through speech therapy, occupational therapy, physical therapy and applied behavior analysis.
- charges for the treatment of Down syndrome through speech therapy, occupational therapy, physical therapy and applied behavioral analysis. Includes habilitative and rehabilitative services.
- 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.

HC-COV1103 03-21

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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.

HC-CNV28 04-14
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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, 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.

HC-BEX42 04-11
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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.

HC-DFS1111 12-17
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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.

HC-ETGARDR

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, 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.

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.

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.

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. In the event any new or additional information

(evidence) is considered, relied upon or generated by Cigna in connection with the level two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

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 and the appeal involves medical judgment or a rescission of coverage, 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 request an appeal to an Independent Review Organization 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.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if a delay would be detrimental to your condition, as determined by Cigna's Physician Reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from the facility, the review shall be completed within 72 hours.

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

HC-APL395 01-20
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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.

HC-ETILRDR

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”.

SCHEDIL-ETC

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.

HC-PAC111 01-20
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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 immunoglobin 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 Necessity 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.

HC-COV939 01-20

ET2

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.

HC-PHR292 01-19
ET

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.

HC-ETINRDR

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.

HC-PHR263 01-20
V1 ET

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 01-19
ET

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

CERTIFICATE RIDER – Kansas Residents

Rider Eligibility: Each Employee who is located in Kansas

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 Kansas group insurance plans covering insureds located in Kansas. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETKSRDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you already have insured Dependents, any additional Dependent children born while such Dependent Insurance is in effect will automatically be enrolled. 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.

Any newborn child adopted by you while you are insured will become insured on the date of his birth and continue for 31 days provided that the petition for adoption is filed within the first 31 days. Any other child adopted by you shall be from the date of placement in the home for the purpose of adoption or the date of petition for adoption. The number of days between the date of placement and the date of the petition shall not exceed 280.

HC-ELG248 01-19
ET

Covered Expenses

Autism Spectrum Disorders

- charges made for all generally recognized services prescribed in relation to Autism Spectrum Disorder for Dependent children. Such coverage must be prescribed by a Physician, in a treatment plan and shall include evaluation and assessment services; applied behavior analysis; speech therapy; occupational therapy; and physical therapy.
- Autism Spectrum Disorder 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.
- charges made for diagnostic mammograms and Papanicolaou laboratory screening tests, including services performed at a certified mobile facility.

Mammograms

Charges made for mammograms including services up to and including tomosynthesis, or 3D mammography when performed at the direction of a person licensed to practice medicine and surgery by the board of healing arts within the lawful scope of such person's license, including services performed at a mobile facility certified by the federal health care financing administration and performing mammography testing by American Cancer Society guidelines.

HC-COV895 01-20
ET2

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

The Schedule

The Medical Schedule in your certificate is amended to include the following provision (subject to the same terms and conditions as any other illness):

Elective Abortion
Abortion means the use or prescription of any instrument, medicine, drug or any other substance or device to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes in utero, accidental trauma or a criminal assault on the pregnant woman or her unborn child and which causes the premature termination of the pregnancy. **Elective** means an abortion for any reason other than to prevent the death of the mother upon whom the abortion is performed; provided, that an abortion may not be deemed one to prevent the death of the mother based on a claim or diagnosis that she will engage in conduct which will result in her death.

HC-RDR37 04-10
V1-ET

Definitions

Review Organization

The term Review Organization means any entity which conducts utilization review and determines certification of an admission, extension of stay or other health care service.

HC-DFS808 12-15
V2 ET

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

CERTIFICATE RIDER – Louisiana Residents

Rider Eligibility: Each Employee who is located in Louisiana

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 Louisiana group insurance plans covering insureds located in Louisiana. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETLARDR

Covered Expenses

- charges for treatment of severe mental illness, on the same basis as other Sickness covered under the plan. "Severe mental illness" includes:
  - schizophrenia or schizoaffective disorder;
  - bipolar disorder;
  - panic disorder;
  - obsessive-compulsive disorder;
  - major depressive disorder;
  - anorexia/bulimia;
  - intermittent explosive disorder;
  - post-traumatic stress disorder;
  - psychosis NOS (not otherwise specified) when diagnosed in a child under age 17;
  - Rett's Disorder; and
  - Tourette's Disorder.

Autism Spectrum Disorder

- charges for the diagnosis and treatment of Autism Spectrum Disorders, including applied behavioral analysis. Such coverage shall include the following care prescribed, provided or ordered by a Physician or a Psychologist who is licensed in this state who shall supervise provision of such care:
  - Medically Necessary assessments, evaluations, or tests to diagnose an Autism Spectrum Disorder;
  - habilitative or rehabilitative care;
  - pharmacy care;
  - psychiatric care;
  - psychological care; and
  - therapeutic care.

Autism Spectrum Disorders include any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including Autistic Disorder, Asperger's Disorder and Pervasive Developmental Disorder – Not Otherwise Specified. Benefits for the diagnosis and treatment of Autism Spectrum Disorders are payable on the same basis as any other Sickness covered under the plan.

HC-COV952 ET1

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. Speech, physical and occupational therapies are covered for Autism Spectrum Disorders, and developmental delays and learning disabilities.

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 speech disorders 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; and
- 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.
- speech, physical, occupational, or cognitive rehabilitation to treat learning disabilities, autism spectrum disorders, developmental delays, intellectual disabilities, or attention deficit disorders.

Chiropractic Care Services

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; and
- vitamin therapy.

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

HC-COV254 12-17
ET

Prescription Drug Benefits

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 Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule. Coverage includes charges for Medically Necessary drugs, prescribed by a Physician, for the treatment of metastatic or unresectable tumors. Your benefits may vary depending on which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

Modifications to drug coverage under a health plan may be made only if the modification occurs at time of coverage renewal. You will be notified of any of the following modifications to the Prescription Drug List:

- Removing a drug from the formulary;
- Adding a requirement that an enrollee receive prior authorization for a drug;
- Imposing or altering a quantity limit for a drug; and
- Moving a drug to a higher cost sharing tier (unless a generic drug alternative to the drug is available).

HC-PHR438 ET

Limitations

Step Therapy

When medications for the treatment of any medical condition are restricted for use by a step therapy or fail first protocol, the prescribing Physician shall have access to a clear and convenient process to expeditiously request an override of such restriction from the insurer. An override shall be granted for the following circumstances:

- The prescribing Physician can demonstrate that the preferred treatment required under step therapy or fail first protocol has been ineffective in the treatment of the medical condition.
- The prescribing Physician can demonstrate that the preferred treatment required under the step therapy or fail first protocol is reasonably expected to be ineffective based on the known relevant physical or mental characteristics and medical history of the insured and known characteristics of the drug regimen.
- The prescribing Physician can demonstrate that the preferred treatment required under the step therapy or fail first protocol will cause or will likely cause an adverse reaction or other physical harm to the insured.

The duration of any step therapy protocol shall not be longer than the customary period for the medication when such treatment is demonstrated by the prescribing Physician to be clinically ineffective. When the plan can demonstrate that the originally prescribed medication is likely to require more than the customary period for the medication to provide any relief or an amelioration to the insured, the step therapy or fail first protocol may be extended for an additional period of time no longer than the original customary period for the medication.

No plan shall use step therapy or fail first protocols as the basis to restrict any prescription benefit for the treatment of stage-four advanced, metastatic cancer or associated conditions if at least one of the following criteria is met:

- The prescribed drug or drug regimen has the United States Food and Drug Administration approved indication.
- The prescribed drug or drug regimen has the National Comprehensive Cancer Network Drugs and Biologics Compendium indication.
- The prescribed drug or drug regimen is supported by peer-reviewed, evidenced-based medical literature.

These provisions will apply if the preferred drug or regimen is considered clinically equivalent for therapy, contains the

identical active ingredient or ingredients, and is proven to have the same efficacy.

For drugs prescribed for associated conditions, the treating healthcare provider shall inform the plan that the condition is one associated with stage-four advanced, metastatic cancer when requesting authorization.

A determination for an override request will be rendered within 72 hours for a standard request, and 24 hours for an urgent request. If the plan fails to comply with the timelines, the override request shall be considered approved.

HC-PHR437 ET1

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

Termination of Insurance

Continuation

Continuation of Medical Insurance during Active Military Duty

If your coverage would otherwise cease because you are a Reservist in the United States Armed Forces and are called to active duty, the insurance for you and your Dependents will be continued during your active duty only if you elect it in writing, and will continue until the earliest of the following dates:

- 90 days from the date your military service ends;
- the last day for which you made any required contribution for the insurance; or
- the date the group policy cancels.

Additionally, a Dependent who is called to active duty will not cease to qualify for Dependent coverage due to his/her active duty status if he or she has elected to continue coverage in writing. Coverage will be continued for that Dependent during his or her active duty until the earliest of the following dates:

- the date insurance ceases.
- the last day for which the Dependent has made any required contribution for the insurance;
- the date the Dependent no longer qualifies as a Dependent; or
- the date Dependent Insurance is canceled.

Reinstatement of Medical Insurance

If your coverage ceases because you are a Reservist in the United States Armed Forces and are called to active duty, the insurance for you and your Dependents will be automatically reinstated after your deactivation, provided that you return to Active Service within 90 days.

If coverage for your Dependent has ceased because he or she was called to active duty, the insurance for that Dependent will be automatically reinstated after his or her deactivation, provided that he or she otherwise continues to qualify for coverage.

Such reinstatement will be without the application of: a new waiting period, or a new Pre-existing Condition Limitation. A new Pre-existing Condition Limitation will not be applied to any condition that you or your Dependent developed while coverage was interrupted. The remainder of a Pre-existing Condition Limitation which existed prior to interruption of coverage may still be applied.

HC-TRM81 04-10
V1-ET1

Dependent

Dependents are:

- your lawful spouse; and
- any child of yours who is
  - less than 26 years old.
  - your eligible dependent as determined under the terms of the Employer's plan and reported by the Employer to Cigna. An eligible Dependent include spouse, children under 26 years of age, and grandchildren under 26 years of age who are in the legal custody of and residing with the grandparent.
  - 26 or more years old, 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. After the first two years following the child's attainment of the limiting age, 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 under the age of 26 who is legally adopted by you, including a child who is placed in your home according to an adoption Placement agreement executed with a licensed adoption agency effective from the date of Placement in your home, or any child, following execution of an act of voluntary surrender in favor of you or your legal representative effective from the date on which the act of voluntary surrender becomes irrevocable. It also includes:

- a stepchild;
- any grandchild of yours provided such child is under 26 years of age, or in the case of full-time students, under years of age, and is in your legal custody;
- any grandchild of yours who is in your legal custody, and is incapable of self-sustaining employment by reason of intellectual or physical disability which existed prior to the child's 26th birthday.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent spouse. A child under age 26 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee.

No one may be considered as a Dependent of more than one Employee.

HC-DFS1575 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
V1-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 Under the Medical Plan

- charges made for or in connection with: (a) an annual cytologic screening (Pap smear) for detection of cervical cancer; (b) a single baseline mammogram for women ages 35 through 39. The total amount payable (including

Deductibles and Copayments) for the mammogram cannot exceed 130% of the Medicare reimbursement amount. The provider may only bill for Deductibles and Copayments up to that amount and they may not Balance Bill for any charges over that. Screening mammography's must be performed in a health care facility or mobile mammography screening unit that is accredited under the American College of Radiology Accreditation Program or in a hospital; (c) 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 (d) an annual mammogram for women ages 50 through 64. Your provider will indicate whether your mammogram is for preventive or diagnostic purposes.

- charges for any medical services necessary to administer prescribed off-label drugs.
- charges for any medical services necessary to administer prescribed off-label drugs.

Dedicated Virtual Providers/Telemedicine

- charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through synchronous or asynchronous information and communication technology.

Virtual Physician Services/Telemedicine

- charges for the delivery of medical and health-related services and consultations as medically appropriate through synchronous or asynchronous information and communication technology that are similar to office visit services provided in a face-to-face setting.
- charges made for Medically Necessary Synchronous Teledentistry.

HC-COV961 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-PHR429 ET

Termination of Insurance

Special Continuation of Medical and/or Dental 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;
- the date the group policy is canceled.

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.

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 are eligible for unemployment compensation benefits; 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.

HC-TRM140 12-18 ET

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 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.

"**Step Therapy Exemption**" means an overriding of a step therapy protocol in favor of immediate coverage of the health care provider's selected prescription drug.

"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, contractual benefits, or a rescission of coverage, 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 Organization (NAO)
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 800.Cigna.24/800.244.6224 or 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.

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 non-authorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, 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.

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.

Step Therapy Exemption Appeals

We will respond with an approval or denial within 48 hours for a request related to urgent care services and 10 calendar days for all other requests.

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. 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/ConsCompl.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: information sufficient to identify the claim; 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; 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 benefit 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 until you have completed the Level One Appeal process.

HC-APL357 03-19
ET

Definitions

Synchronous, Real Time Communication

A live, two-way interaction between a patient and a dentist conducted through audiovisual technology.

HC-DFS1335 03-19
ET

Teledentistry

The delivery of dental services through the use of synchronous, real-time communication and the delivery of services of a dental hygienist or expanded function dental auxiliary pursuant to a dentist's authorization.

HC-DFS1336 03-19
ET

Telemedicine/Virtual Care

Telemedicine services means a mode of providing health care services through synchronous or asynchronous information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where the recipient is located.

HC-DFS1526 ET

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 – 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

V1-ET

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-ETTXRDR

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 Mastecomy 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 audiologically 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 funduscopic 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 01-20
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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
ET

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 01-20
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Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent; (hereinafter individually and collectively referred to as a "Participant,") for which a party may be responsible as a result of having caused or contributed to an Injury or Sickness except for expenses relating to other benefits plans that provide insurance coverage for the Participant (excluding Part B of Medicare).
- 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.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent proceeds do not exceed the "Subrogation Limit Amount", which is defined as the lesser of:
- one half of the Participant's gross recovery from such party, less (as applicable) (i) fees and pro rata shares of expenses incurred in connection with the recovery action to be paid to

the Participant's attorneys pursuant to an agreement between the plan and those attorneys, (ii) in the absence of an agreement, any amounts awarded by a court to the Participant's attorneys from the plan's total gross recovery from such party that constitute reasonable fees for the recovery of proceeds for the plan (not to exceed one-third of the plan's recovery amount) or (iii) in the absence of an agreement, amounts awarded and apportioned by a court to the Participant's attorneys and the plan's attorneys out of any subrogation recovery (not to exceed one-third of the plan's recovery amount) (the foregoing items (i)-(iii) referred to hereinafter as (the "Recovery Fees")) or

- the total cost of any benefits paid, provided or assumed under the plan as a direct result of the tortious conduct of such party, less the Recovery Fees (as applicable).
- A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent the proceeds of any recovery do not exceed the Subrogation Limit Amount.

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan for any recovery amounts obtained by or on behalf of the Participant, not to exceed the Subrogation Limit Amount, against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided that such lien and assignment shall not apply to (a) reasonable fees and pro rata shares of expenses incurred in connection with the recovery action to be paid to the Participant's attorneys pursuant to an agreement between the plan and those attorneys or (b) amounts awarded by a court to the Participant's attorneys that constitute reasonable fees for the recovery of proceeds for the plan (not to exceed one-third of the plan's recovery amount);
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan, except for (a) reasonable fees and pro rata shares of expenses incurred in connection with the recovery action to be paid to the Participant's attorneys pursuant to an agreement between the plan and those attorneys or (b) amounts awarded by a court to the Participant's attorneys that constitute reasonable fees for the recovery of proceeds for the plan (not to exceed one-third of the plan's recovery amount). This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause

irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

- Participants must assist the plan in pursing any subrogation or recovery rights by providing requested information.

HC-SUB84 10-16

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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V1-ET

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.

HC-BEX17 04-10
V1-ET

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.

If you request that your appeal be expedited based on (a) above, 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.

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. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the complaint appeal, Cigna will provide this information to you as soon as possible and

sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

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. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

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. If you request that your appeal be expedited based on (a) above, 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.

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.

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 and the appeal involves medical judgment or a rescission of coverage, 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.

In order to request a referral to an IRO, the reason for the denial must be based on 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 review, you must notify the Appeals Coordinator within four months of your receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna's reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the external review shall be completed within 72 hours.

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.

HC-APL296 04-18
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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 – Utah Residents

Rider Eligibility: Each Employee who is located in Utah

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 Utah group insurance plans covering insureds located in Utah. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETUTRDR

Eligibility - Effective Date

Exception for Newborns

Any Dependent child born or adopted (and placed with you within 30 days of birth) while you are insured will become insured on the date of his birth if you elect Dependent Insurance, according to the following:

If enrolling the adopted or newborn child changes the premium no later than 31 days after his birth.

If additional premium is not required for the newborn or adopted child to receive coverage, the certificate holder must enroll a newly born or adopted child no later than 30 days after the first notification of denial of a claim for services for that child.

If you do not elect to insure your newborn or adopted child within such time, coverage for that child will end on the 31st day after birth. No benefits for expenses incurred beyond the 31st day will be payable.

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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 to help. If you have a concern regarding a person, a service, the quality of care, or 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.

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 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 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, 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.

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.

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.

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

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 review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days, unless the review is expedited. An expedited independent review is available if the adverse benefit determination: (a) involves a medical condition which would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; (b) in the opinion of the your attending provider, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse benefit determination; or (c) concerns an admission, availability of care, continued stay or health care service for which you

received emergency services, but have not been discharged from a facility. The Independent Review Organization will as soon as possible, but no later than 72 hours after receipt of the request for an expedited independent review, make a decision to uphold or reverse the adverse benefit determination.

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

Assistance from the State of Utah

You have the right to contact the Utah State Department of Insurance for assistance at any time. The Utah State Department of Insurance may be contacted at the following address and telephone number:

Utah State Department of Insurance
State Office Building, Room 3110
Salt Lake City, UT 84114-6901
800-439-3805

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. However, you may not initiate a legal action against Cigna until the earliest of: (a) 60 days after proof of loss has been furnished as required under the plan; (b) waiver by Cigna of proof of loss; or (c) Cigna’s denial of full payment. However, no action will be brought at all unless brought within three years after proof of claim is required under the plan.

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