City of Boulder

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2020

ETALLM20A
3338899

This document printed in September, 2019 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: City of Boulder
Rider Eligibility: Each Employee as noted within this certificate rider
Policy No. or Nos.: 3338899
Effective Date: January 1, 2020

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 Colorado:

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

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

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

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

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

Anna Krishtul, Corporate Secretary

HC-ETRDR

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

CERTIFICATE RIDER – Alabama Residents

Rider Eligibility: Each Employee who is located in Alabama

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

HC-ETALRDR

Covered Expenses

- charges for inpatient care for a mother and her newborn for 48 hours after a vaginal delivery and 96 hours after a caesarean section as requested by the perinatal care Physician, OB/GYN, certified nurse midwife, or the child's attending pediatrician. A length of stay beyond 48 or 96 hours will be covered if determined Medically Necessary. Early discharge will be permitted provided the requirements noted above have been met. All children are covered from birth.
- charges for a biennial mammogram for women ages 40 to 49 and an annual mammogram for women age 50 and over. Cigna HealthCare standardly provides coverage for all necessary mammograms when ordered by a woman's Physician. Payment will be made for all charges related to the mammogram. Benefits will be paid the same as any other Covered Expense.

HC-COV427 05-15
HC-COV641 12-17
ET

The Schedule

The pharmacy Schedule is amended to indicate the following:

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

If Specialty Drugs are limited to a 30-day supply at a Home Delivery Network Pharmacy then the following will apply:

Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill and are subject to the same Copayment or Coinsurance that applies to Retail Pharmacies.

SCHED90EQ-alet

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

Arizona

Important Notice

This notice is to advise you that you can obtain a replacement Appeals Process Information Packet by calling the Customer Service Department at the telephone number listed on your

identification card for "Claim Questions/Eligibility Verification" or for "Member Services" or by calling 1-800-244-6224.

The Information Packet includes a description and explanation of the appeal process for Cigna.

Provider Lien Notice

Arizona law entitles health care providers to assert a lien for their customary charges for the care and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. If you are injured and have a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, your health care provider may assert a lien against available proceeds from any such insurer or payor in an amount equal to the difference between the sum, if any, payable to the health care provider under this Plan and the health care provider's full billed charges.

Notice

This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.

HC-IMP8 04-10
V1-ET

Eligibility - Effective Date

Reinstatement of Benefits for Military Returnees

If your coverage ends when you are called to active duty and you are reemployed by your current Employer, coverage for you and your Dependents (including a Dependent born during the period of active military duty) may be reinstated if you applied for reinstatement within 90 days from the date of discharge or within one year of hospitalization continuing after discharge.

HC-ELG231 01-19
ET

Definitions

Emergency Services

Out-of-Network

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency. You are covered for at least a screening examination to determine whether an emergency exists. Care up and through stabilization for emergency situations will be covered without prior authorization.

Emergency Services

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

HC-DFS409 04-10
V1-ET

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

CERTIFICATE RIDER – California Residents

Rider Eligibility: Each Employee who is located in California

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 California for group insurance plans covering insureds located in California. These provisions supersede any

provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETCARDR

Covered Expenses

- charges made for services related to the diagnosis, treatment, and management of osteoporosis. Covered services include, but are not limited to, all FDA approved technologies, including bone mass measurement technologies as deemed Medically Necessary.
- charges made for a drug that has been prescribed for purposes other than those approved by the FDA will be covered if:
  - the drug is otherwise approved by the FDA;
  - the drug is used to treat a life-threatening condition or, a chronic and seriously debilitating condition and the drug is Medically Necessary to treat that condition;
  - the drug has been recognized for the treatment prescribed by any of the following: the American Hospital Formulary Service Drug Information, one of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology; The National Comprehensive Cancer Network Drug and Biologics compendium; The Thomson Micromedix Drug Dex ; or two articles from major peer reviewed medical journals that present data supporting the proposed use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.
- charges for federal Food and Drug Administration (FDA)-approved prescription contraceptive methods, as designated by Cigna. If your Physician determines that none of the methods designated by Cigna are medically appropriate for you because of your medical or personal history, Cigna will cover the alternative FDA-approved prescription contraceptive prescribed by your Physician.

HC-COV584 10-16

ET1

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - the subject of an ongoing phase I, II, or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

  In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed, and is recognized as safe and effective for the treatment of cancer in any of the standard reference compendia: (A) The American Hospital Formulary Service's Drug Information, (B) One of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i). The Elsevier Gold Standard's Clinical Pharmacology; (ii) The National Comprehensive Cancer Network Drug and Biologics compendium; (iii) The Thomson Micromedix DrugDex (C) two articles from major peer-reviewed medical journals that that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory

evidence presented in a major peer-reviewed medical journal.

- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, facility charges and charges for general anesthesia or deep sedation which cannot be administered in a dental office are covered when Medically Necessary. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are also covered provided a continuous course of dental treatment is started within six months of an accident.

HC-EXC279 10-16
ET 2

Definitions

Dependent

Dependents includes:

- your Domestic Partner.

If your Domestic Partner has a child, that child will also be included as a Dependent.

HC-DFS1023 10-16
ET1

Domestic Partner

A Domestic Partner is defined as your Domestic Partner who has registered the domestic partnership by filing a Declaration of Domestic Partnership with the California Secretary of state pursuant to Section 298 of the Family Code or an equivalent document issued by a local agency of California, another state, or a local agency of another state under which the partnership was created.

HC-DFS1024 10-16
ET

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

CERTIFICATE RIDER – Connecticut Residents

Rider Eligibility: Each Employee who is located in Connecticut

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

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

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

HC-ETCTRDR

Covered Expenses

Craniofacial Disorders

Coverage for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders shall be provided for individuals eighteen years of age or younger, if such processes and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association. No coverage shall be provided for cosmetic surgery.

HC-COV654 12-17
ET1

Definitions

Dependent

The following provision is added in the Dependent definition found in your medical certificate:

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

Connecticut law allows same-sex marriages, and grants parties to a civil union the same benefits, protections and

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

HC-DFS915 10-16

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

CERTIFICATE RIDER – Florida Residents

Rider Eligibility: Each Employee who is located in Florida

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

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

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

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

HC-ETFLRDR

Eligibility – Effective Date

Dependent Insurance

Effective Date of Dependent Insurance

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

HC-ELG171 01-18
ET

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 made for medical, surgical and Hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous

abortion (miscarriage) and complications of pregnancy. Services provided to you by a certified nurse-midwife or a licensed midwife, in a home setting or in a licensed birthing center. Coverage for a mother and her newborn child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. Post delivery care for a mother and her newborn shall be covered. Post delivery care includes: a postpartum assessment and newborn assessment, which can be provided at the hospital, the attending Physician's office, and outpatient maternity center or in the home by an Other Health Care Professional trained in mother and newborn care. The services may include physical assessment of the newborn and mother, and the performance of any clinical tests and immunizations in keeping with prevailing medical standards.

- 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 and Medically Necessary follow-up evaluations. When ordered by the treating Physician, a newborn's hearing screening must include auditory brainstem responses or evoked otacoustic emissions or other appropriate technology approved by the FDA. All screenings shall be conducted by a licensed audiologist, Physician, or supervised individual who has training specific to newborn hearing screening. Newborn means an age range from birth through 29 days. Infant means an age range from 30 days through 12 months.

In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below, for a Dependent child who is age 15 or less, for charges made for Child Preventive Care Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

- a history;
- physical examination;
- development assessment;
- anticipatory guidance; and
- appropriate immunizations and laboratory tests;

excluding any charges for:

- more than one visit to one provider for Child Preventive Care Services at each of the Approximate Age Intervals, up to a total of 18 visits for each Dependent child;
- services for which benefits are otherwise provided under this Covered Expenses section;
- services for which benefits are not payable, according to the Expenses Not Covered section.

It is provided that any Deductible that would otherwise apply will be waived for those Covered Expenses incurred for Child Preventive Care Services. Approximate Age Intervals are: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years and 15 years.

HC-COV644 01-18
ET

Short-Term Rehabilitative Therapy and Spinal Manipulation Care Services

Any references to "Chiropractic Care" are hereby changed to "Spinal Manipulation".

HC-COV53 04-10
V1-ET

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

V1-ET

Termination of Insurance

Special Continuation of Medical Insurance For Dependents of Military Reservists

If your insurance ceases because you are called to active military duty in: the Florida National Guard; or the United States military reserves, you may elect to continue Dependent insurance. You must pay the required premiums to the Policyholder if you choose to continue Dependent insurance. In no event will coverage be continued beyond the earliest of the following dates:

- the expiration of 30 days from the date the Employee's military service ends;
- the last day for which the required contribution for Dependent insurance has been made;
- the date the Dependent becomes eligible for insurance under another group policy. Coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is excluded from this provision;
- the date the Dependent becomes eligible for Medicare (this does not apply to Vision insurance);
- the date the group policy cancels;
- the date the Dependent ceases to be an eligible Dependent.

Reinstatement of Medical Insurance - Employees and Dependents

Upon completion of your active military duty in: the Florida National Guard; or the United States military reserves, you are entitled to the reinstatement of your insurance and that of your Dependents if continuation of Dependent insurance was not elected. Such reinstatement will be without the application of: any new waiting periods; or the Pre-existing Condition Limitation to any new condition that you or your Dependent may have developed during the period that coverage was interrupted due to active military duty.

Provisions Applicable to Reinstatement

- You must notify your Employer, before reporting for military duty, that you intend to return to Active Service with that Employer; and
- You must notify your Employer that you elect such reinstatement within 30 days after returning to Active Service with that Employer and pay any required premium.

Conversion Available Following Continuation

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

HC-TRM131 01-18
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, 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
ET

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
ET

Spinal Manipulation Care

The term Spinal Manipulation Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

HC-DFS164 04-10
V1-ET

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

Covered Expenses

- charges made for colorectal cancer screening, examinations and laboratory tests according to the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology, if deemed appropriate by the Physician in consultation with the insured.

HC-COV660 01-18
ET2

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

Important Notices

Illinois Notice

Notice to All Female Plan Members: Your Right to Select A Woman's Principal Health Care Provider

Illinois law allows you to select "a woman's principal health care provider" in addition to your selection of a Primary Care Physician. "A woman's principal health care provider" is a Physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice. "A woman's principal health care provider" may be seen for care without referrals from your Primary Care Physician. If you have not already selected "a woman's principal health care provider," you may do so now or at any other time. You are not required to have or to select "a woman's principal health care provider."

Your "woman's principal health care provider" must be a part of your plan. You may get the list of participating

obstetricians, gynecologists, and family practice specialists from your Employer's employee benefits coordinator, or for your own copy of the current list, you may call the toll-free Member Services number on your ID card. The list will be sent to you within 10 days after your call. To designate "a woman's principal health care provider" from the list, call the toll-free Member Services number on your ID card and tell our staff the name of the Physician you have selected.

HC-IMP14 04-10

V1-ET

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

Covered Expenses

- charges for colorectal cancer screening with sigmoidoscopy or fecal occult blood testing once every 3 years for: persons age 50 and older; or persons age 40 and older who are considered high risks for colorectal cancer.
- charges for treatment of mental, emotional or nervous disorders or conditions, including serious mental illness on the same basis as any other Sickness covered under the plan. Coverage includes any of the following psychiatric illnesses as listed in the most current edition of the Diagnostic and Statistical Manual (DSM):
  - schizophrenia;
  - paranoid and other psychotic disorders;
  - bipolar disorders (hypo-manic, manic, depressive and mixed);
  - major affective disorders (single episode or recurrent);
  - schizo-affective disorders (bipolar or depressive);
  - pervasive developmental disorders;
  - obsessive compulsive disorders;
  - depression in childhood and adolescence;
  - panic disorder;
  - post-traumatic stress disorders (acute, chronic, or with delayed onset); and
  - eating disorders, including anorexia nervosa, bulimia nervosa, pica, rumination disorder, avoidant/restrictive food intake disorder, other specified feeding or eating disorder (OSFED), and any other eating disorder contained in the most recent version of the DSM of Mental Disorders.
- 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 the removal of breast implants when the removal of the implant is Medically Necessary treatment for a sickness or injury.
- 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 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.

HC-COV427 05-15
HC-COV667 01-18
ET

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-PHR258 01-18
ET

Definitions

Dependent – For Vision Benefits

Dependents include:

- your lawful spouse, including your civil union partner (The Religious Freedom Protection Act and Civil Union Act, 750 ILCS 75, allows both same-sex and different-sex couples to

enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples).

HC-DFS799 07-15
V1-ET1

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

Indiana Notice

Cigna Health and Life Insurance Company Claim Offices Servicing Indiana

We are here to serve you.

As our certificate holder, your satisfaction is very important to us. If you have a question about your certificate, if you need assistance with a problem, or if you have a claim, you should first contact your Benefits Administrator or us at the numbers and addresses listed below. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion.

Medical Questions

Cigna Health and Life Insurance Company
Midwest Claim Service Center
P.O. Box 2100
Bourbonnais, IL 60914 Tel. 1-800-Cigna24

Should you feel you are not being treated fairly with respect to a claim, you may contact the Indiana Department of Insurance with your complaint.

To contact the Department, write or call:

Consumer Services Division
Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, IN 46204 – 2787
1-800-622-4461 or 1-317-232-2395

HC-IMP41 04-10
V1

Covered Expenses

- charges for reimbursement payments made to the Indiana First Steps program for Early Intervention Services incurred by a Dependent child enrolled in the program, from birth through age two. Payments made directly by the program will be credited toward Deductibles or Copayments.
- coverage for or in connection with expenses arising from medical and dental care (including orthodontic and oral surgery treatment) involved with the management of cleft lip and cleft palate.
- charges made for mammograms including, but not limited to:
  - a single baseline mammogram for women ages 35 through 39;
  - an annual mammogram for women under age 40 who are considered to be at risk;
  - an annual mammogram for women age 40 and over;
  - additional mammography views when necessary for proper evaluation; and
  - ultrasound services when considered by the treating Physician to be medically necessary.

HC-COV666 01-18
ET2

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 01-18
ET

Definitions

Dependent

The term child means a legally adopted child including: a child who has been placed with you for adoption provided the child is not removed from placement prior to legal adoption or a child for whom entry of an order granting custody to you has been made.

HC-DFS283 04-10
V2-ET

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

CERTIFICATE RIDER – Iowa Residents

Rider Eligibility: Each Employee who is located in Iowa

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

HC-ETIARDR

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

Important Notice

This notice is to advise you that Cigna will, upon request, provide you with the following:

- a complete description of health care services; a description of limitations and exclusions; prior authorization policies; restricted drug formularies; other provisions restricting access; a copy of the participating provider directory; notice of plan changes that affect benefits or cost; a description of the available grievance and appeal procedures; and description of your rights regarding termination, disenrollment, nonrenewal, or cancellation of coverage.
- the right to request an independent external review of an adverse decision by the plan when the covered person has exhausted all internal review procedures for nonemergency medical conditions, the covered person has not received a final decision within 60 days of seeking the internal review and did not request the delay, or there is an emergency medical condition. Within 90 days receipt of the adverse decision, the request for external review must be sent in writing to the Commissioner from the covered person, his treating Physician with written authorization, or a legally authorized designee of the covered person. The covered person must provide all pertinent information, an appeal form, and a fully executed release form pertaining to medical records. Upon request from the Commissioner, the

covered person or insurer/HMO must provide pertinent information within five business days. The Commissioner will negotiate contracts with external review organizations, allow the participants to provide additional written information, make a decision on the request within ten business days of receiving all necessary information, and notify the covered person, provider or designee in writing if the request for external review was granted. The external review organization chosen by the Commissioner will issue a binding written decision to the covered person, insurer and Commissioner within 30 business days, expedited resolution when an emergency condition exists within seven business days.

HC-IMP42 04-10
V1-ET

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.

HC-ELG174 02-18
ET

The Schedule

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."

SCHEDDENE-ET1

Covered Expenses

- charges for a prostate-specific antigen (PSA) blood test and a digital rectal examination for a male aged 50 and over regardless of whether or not symptoms are present; and a male aged 40 or over who is symptomatic or who is considered a high risk for prostate cancer.
- abortion when a Physician certifies in writing that the pregnancy would endanger the life of the mother.

Autism Spectrum Disorders

- Charges made for all generally recognized services prescribed in relation to Autism Spectrum Disorder for Dependent children to age 12. 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.

Medical Telehealth – PCP/Specialist

- Charges for the delivery of real-time medical services provided via secure internet-based audio and video technologies which are similar to office visit services provided in a face-to-face setting.
- charges incurred at birth for the delivery and obstetrical expenses of or for the birth mother of a child who is legally adopted by you within 90 days from date of birth, if you choose to file a claim for such expenses, subject to all other terms of these Medical Benefits. This benefit is in excess of the birth mother's coverage.
- charges made for immunizations for a Dependent child from birth to age 6 for: not fewer than 5 doses of vaccine each for diphtheria, pertussis, tetanus; 4 doses polio, Haemophilus influenzae type b; 3 doses Hepatitis B; at least one dose of vaccine each for measles, mumps, rubella, and chicken pox; other vaccines and dosages as prescribed by the secretary of health and environment; and office visit expenses, or equivalent expenses, when incurred while obtaining such vaccinations.
- charges made for diagnostic mammograms and Papanicolaou laboratory screening tests, including services performed at a certified mobile facility.
- charges for a drug that has been prescribed for the treatment of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration if that drug has been recognized as a treatment for cancer in one of the standard reference compendia 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 for diagnosis and treatment of mental illnesses and alcoholism, drug abuse or other substance abuse use

disorders. Mental illness, alcoholism, drug abuse or substance abuse means any disorder as such terms are defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 1994). Coverage is subject to the limits outlined in The Schedule.

Diabetes

The following benefits will apply to insulin and noninsulin-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;
  - Injection aids, including devices used to assist with insulin injection and needleless systems;
  - Insulin syringes;
  - Insulin pumps, and accessories;
  - Glucagon emergency kits.
  - Diabetes outpatient self-management training and education provided by a certified, registered or licensed health care professional with expertise in diabetes if ordered by a professional legally authorized to prescribe such services and the diabetic is treated: at a program approved by the American Diabetes Association; by a person certified by: the National Certification Board for Diabetes Educators; or by a licensed dietitian pursuant to a treatment plan authorized by such health care professional.

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-COV427 06-15
HC-COV645 02-18
ET

Mental Health and Substance Use Disorder Services

Mental Health Services are services that are required to treat a mental illness as specified in the diagnostic and statistical manual of mental disorders, fourth edition, (DSM-IV, 1994) of the American Psychiatric Association. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Use Disorder is defined according to the diagnostic and statistical manual of mental disorders, fourth edition (DSM-IV, 1994) of the American Psychiatric Association as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Use Disorder.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

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

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Partial Hospitalization or Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital

problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

A Mental Health Intensive Outpatient Therapy Program consists of treatment that is provided by a certified/licensed Mental Health program in accordance with the laws of the appropriate, legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Use Disorder Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Residential Treatment services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Substance Use Disorder Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Use Disorder conditions.

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorder Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program.

Substance Use Disorder Partial Hospitalization services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of treatment that is provided by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Use Disorder Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that are administered in an Inpatient setting, Outpatient setting, Physician's office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug Product first.

The Cigna Business Decision Team determines whether utilization management requirements or other coverage conditions should apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. When considering a Medical Pharmaceutical for a coverage status, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

HC-COV573 10-16

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 if applicable at non-participating pharmacies, the same as the out of network medical cost share for injectable/IV chemotherapy.

SCHEDPHARM90-kset

Termination of Insurance

Special Continuation of Medical Insurance

If your insurance would otherwise cease for any reason other than failure to make any required contribution, and if you have been insured for at least three consecutive months, and if you pay the required premium, your Medical Insurance will be continued until the earliest of:

- 18 months from the date the insurance would otherwise cease;
- the last day for which you have paid the required premium;

Within 31 days after the date the insurance would otherwise cease, you may elect such continuation by paying the required premium.

If your insurance is being continued as outlined above, the insurance for any of your Dependents insured on the date your insurance would otherwise cease may be continued, subject to the above provisions. The insurance will be continued until the date your insurance ceases.

Dependent Medical Insurance after Divorce

If insurance for any of your Dependents would otherwise cease because of divorce or annulment of marriage, Medical Insurance for that Dependent may be continued upon payment

of the required premium. However, the insurance on any of your Dependents will cease on the earliest date below:

- 18 months from the date the insurance would otherwise cease;
- the last day for which the required premium has been paid.

In any case, Dependent Insurance on any of your children will cease when that child no longer qualifies as your Dependent for a reason other than one due to dissolution of marriage.

If you die, any other terms which continue Dependent Insurance after your death will apply.

Conversion Available Following Continuation

The provisions of the "Medical Conversion Privilege" section will apply following termination of insurance.

HC-TRM42 04-10
V1-ET

Definitions

Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the plan, this definition also includes:

- The following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips, diabetic pharmaceutical supplies;
- Needles and syringes for self-administered medications or Biologics covered under the plan's Prescription Drug benefit; and
- Inhaler assistance devices and accessories, peak flow meters.

This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

HC-DFS1009 10-16
ET

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 – Massachusetts Residents

Rider Eligibility: Each Employee who is located in Massachusetts

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

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

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

HC-ETMARDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

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

HC-ELG12 04-10
V1-ET

Important Notices

Mental Health Parity

This plan must cover the same or equal benefits for mental health and substance abuse conditions that it covers for other medical conditions. This is called "Mental Health Parity." For example, if your plan offers prescription drug benefits, whether drugs are prescribed for a mental health or medical condition, they must be covered at the same rates. The copayments, deductibles, and maximum lifetime benefits charged for mental health conditions must be the same as those for medical conditions.

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. Coverage for Mental Health Services includes treatment for the following:

- Biologically-based mental disorders as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the DSM); specifically schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post traumatic stress disorder, Substance Abuse disorders, autism and any biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner of the Massachusetts Department of Mental Health in consultation with the commissioner of the Massachusetts Division of Insurance.
- Rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to commit rape, whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims.
- Nonbiologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, that substantially interferes with or substantially limits the functioning and social interactions of children and adolescents under age 19. The interference or limitation must either be: documented by, and the referral for such diagnosis and treatment must be made by, the child or adolescent's Primary Care Provider, primary pediatrician or a licensed mental health professional; or evidenced by conduct, including but not limited to, an inability to attend school as a result of the disorder; the need to hospitalize the child or adolescent as a result of the disorder; or a pattern of conduct or behavior caused by the disorder which poses a threat to the child or adolescent or to others. Benefits for treatment will continue beyond the adolescent's 19th birthday, if the adolescent is engaged in an ongoing course of treatment, until the course of treatment is completed, so long as this health benefits plan remains in effect. Ongoing treatment, if not completed, will also be covered under any subsequent health benefit plan in effect.
- All other mental disorders not otherwise previously provided for, which are described in the most recent edition of the DSM.

Psychopharmacological services and neuropsychological assessment services are covered on the same basis as services for any other Sickness.

In determining benefits payable, charges made for the treatment of biologically-based mental disorders, rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to commit rape, or nonbiologically-based mental, behavioral or emotional disorders of children or adolescents under age 19 are not considered Mental Health Services but are payable on the same basis as for any other Sickness.

Substance Abuse is considered a biologically-based mental disorder as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the DSM).

Your Rights Under Mental Health Parity

- You have the right to coverage for the diagnosis and Medically Necessary treatment of mental illness under the Mental Health Parity law.
- You can change your doctor or other mental health provider if you are not satisfied.
- You can see and get a copy of your medical records. You can add your own notes to your records.
- You have the right to keep your medical information private.
- You can get a second medical opinion when you are given a diagnosis or treatment option.

Complaints Concerning Non-Compliance With Mental Health Parity

Complaints alleging a Carrier's non-compliance with Mental Health Parity may be submitted verbally or in writing to the Division's Consumer Services Section for review. A written submission may be made by using the Division's Insurance Complaint Form. A copy of the form may be requested by telephone or by mail, and the form can also be found on the Division's webpage at:

http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html

Consumer complaints regarding alleged non-compliance with Mental Health Parity also may be submitted by telephone to the Division's Consumer Services Section by calling (877) 563-4467 or (617) 521-7794. All complaints that are initially made verbally by telephone must be followed up by a written

submission to the Consumer Services Section, which must include but is not limited to the following information requested on the Insurance Complaint Form: the complainant's name and address; the nature of the complaint; and the complainant's signature authorizing the release of any information regarding the complaint to help the Division with its review of the complaint. The Division will endeavor to resolve all consumer complaints regarding non-compliance with the Mental Health Parity Laws in a timely fashion.

HC-IMP133 04-14

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The Schedule

Short-Term Rehabilitative Therapy

Any maximum that applies to Short-Term Rehabilitative Therapy Services shown in The Schedule does not apply to Speech and Hearing Services.

External Prosthetic Appliances

If you are enrolled in a Network, Exclusive Provider Organization, or Open Access Plus In-Network medical plan, no separate External Prosthetic Appliances maximum or deductible will apply. External Prosthetic Appliances will be covered at "No charge".

If you are enrolled in a Network Point of Service medical plan, no separate External Prosthetic Appliances maximum or deductible will apply. In-Network External Prosthetic Appliances will be covered at "No charge".

If you are not enrolled in a Network, Network Point of Service, Exclusive Provider Organization, or Open Access Plus In-Network medical plan, any maximum that applies to External Prosthetic Appliances Services shown in The Schedule does not apply to External Prosthetic Appliances meant to replace an arm or leg, in whole or in part.

Substance Abuse

The Schedule entry "Substance Abuse" is hereby changed to read "Substance Abuse" (a biologically-based mental disorder, payable on the same basis as for other sickness)".

For charges made for Substance Abuse, no separate maximums will apply and Covered Expenses will be payable the same as for other illnesses, including accumulation to any Out-of-Pocket amount and any increase to 100% once the Out-of-Pocket amount has been reached. Outpatient Substance Abuse charges will be paid at the same level as the Primary Care Provider's Office visit.

SCHEDMA-ET1

Covered Expenses

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

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

Excluding any charges for:

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

Approximate Intervals are:

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

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

These services must be delivered by certified early intervention specialists, as defined by the early intervention operational standards by the Massachusetts Department of Public Health and in accordance with applicable certification requirements.

- charges made for or in connection with mammograms for breast cancer screening, not to exceed: one baseline mammogram for women age 35 but less than 40, and a mammogram annually for women age 40 and over.

- charges made for or in connection with the treatment of metastatic breast cancer by bone marrow transplants provided the treatment follows the guidelines reviewed and approved by the National Cancer Institute.
- charges for a scalp hair prosthesis worn for hair loss due to the treatment of any form of cancer or leukemia, provided that a Physician verifies in writing that the scalp hair prosthesis is Medically Necessary.
- charges for a newborn hearing screening test performed before the newborn is discharged from the Hospital or birthing center.
- charges made for screening for lead poisoning of a Dependent child from birth until 6 years of age.
- charges for Medically Necessary diagnosis and treatment of speech, hearing and language disorders by individuals licensed as speech-language pathologists or audiologists, if such services are rendered within the lawful scope of practice for such practitioners, regardless of whether the services are provided in a Hospital, clinic or private office, and if such coverage does not extend to the diagnosis or treatment of speech, hearing and language disorders in a school-based setting.
- charges for treatment of an Injury or Sickness of an eligible newborn or adopted child, including the necessary care and treatment of medically-diagnosed congenital defects and birth abnormalities or premature birth.
- charges for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section for a mother and her newborn child. Any decision to shorten such minimum coverage will be made in accordance with rules and regulations promulgated by the Massachusetts Department of Public Health relative to early discharge (less than 48 hours for a vaginal delivery and 96 hours for a caesarean delivery) and postdelivery care, including but not limited to: home visits; parent education; assistance and training in breast or bottle feeding; and the performance of any necessary and appropriate clinical tests. The first home visit may be conducted by a registered nurse, Physician or certified nurse-midwife. Any subsequent home visit determined to be clinically necessary must be provided by a licensed health care provider.
- charges for the diagnosis and treatment of autism spectrum disorder. Autism spectrum disorders are any of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. These disorders include: autistic disorder; Asperger's disorder; and pervasive developmental disorders not otherwise specified.

  Diagnosis includes the following: Medically Necessary assessments; evaluations, including neuropsychological evaluations; genetic testing; or other tests to diagnose whether an insured has one of the autism spectrum disorders.

  Treatment includes the following care when prescribed, provided or ordered by a licensed Physician or licensed Psychologist who determines the care to be Medically Necessary:

  - Habilitative or Rehabilitative;
  - Pharmacy;
  - Psychiatric;
  - Psychological; and
  - Therapeutic.

  Habilitative or Rehabilitative care means professional counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual. Applied behavior analysis includes the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

  Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

  Psychological care means direct or consultative services provided by a Psychologist licensed in the state in which the Psychologist practices.

  Therapeutic care includes services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

  Pharmacy care is included to the same extent that such care is provided by the policy for other medical conditions.

  The guidelines used by Cigna to determine if coverage for the diagnosis and treatment of autism spectrum disorder is Medically Necessary will be:

  - developed with input from practicing Physicians in the insurer's Service Area;
  - developed in accordance with the standards adopted by national accreditation organizations;
  - updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
  - evidence-based, if practicable.

  In applying such guidelines, Cigna will consider the individual health care needs of the insured.

Benefits are payable on the same basis as for the diagnosis and treatment of other physical conditions. No annual or lifetime visit or dollar limits apply to the diagnosis and treatment of autism spectrum disorder, nor will Cigna require that visits for the diagnosis and treatment of autism spectrum disorder be completed within a fixed number of days.

No coverage is provided for services to an individual under: an individualized family service plan; an individualized education program; an individualized service plan; or for services related to autism spectrum disorder provided by school personnel under an individualized education program.

- charges made for hormone replacement therapy services for peri- and postmenopausal women and for outpatient contraceptive drugs or devices which have been approved by the Food and Drug Administration (FDA), under the same terms and conditions as for other outpatient prescription drugs and devices.
- charges made for nonprescription enteral formulas to treat malabsorption caused by Crohn's disease or ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited disorders of amino and organic acid metabolism. Foods modified to be low protein for use by a person with disorders of amino and organic acid metabolism are covered.
- charges made for cardiac rehabilitation, according to standards developed by the Massachusetts Department of Public Health. Cardiac rehabilitation means a multidisciplinary, Medically Necessary treatment of persons with documented cardiovascular disease, provided in either a Hospital or other setting and meeting standards set forth by the Massachusetts Commissioner of Public Health.
- coverage for the cost of HLAT or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. Coverage includes the cost of testing for A, B, or DR antigens, or any combination thereof, consistent with rules, regulations, and criteria established by the Department of Public Health.
- charges for medical or drug treatments to correct or repair disturbances of body composition caused by HIV associated lipodystrophy syndrome including, but not limited to reconstructive surgery, such as suction assisted lipectomy, other restorative procedures and dermal injection or fillers for reversal of facial lipoatrophy syndrome.

Covered Expenses

Mental Health and Substance Use Disorder Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. Coverage for Mental Health Services includes treatment for the following:

- Biologically-based mental disorders as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the DSM); specifically schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post traumatic stress disorder, Substance Abuse disorders, autism and any biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner of the Massachusetts Department of Mental Health in consultation with the commissioner of the Massachusetts Division of Insurance.
- Rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to commit rape, whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims.
- Nonbiologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, that substantially interferes with or substantially limits the functioning and social interactions of children and adolescents under age 19. The interference or limitation must either be: documented by, and the referral for such diagnosis and treatment must be made by, the child or adolescent's Primary Care Provider, primary pediatrician or a licensed mental health professional; or evidenced by conduct, including but not limited to, an inability to attend school as a result of the disorder; the need to hospitalize the child or adolescent as a result of the disorder; or a pattern of conduct or behavior caused by the disorder which poses a threat to the child or adolescent or to others. Benefits for treatment will continue beyond the adolescent's 19th birthday, if the adolescent is engaged in an ongoing course of treatment, until the course of treatment is completed, so long as this health benefits plan remains in effect. Ongoing treatment, if not completed, will also be covered under any subsequent health benefit plan in effect.
- All other mental disorders not otherwise previously provided for, which are described in the most recent edition of the DSM.

Psychopharmacological services and neuropsychological assessment services are covered on the same basis as services for any other Sickness.

In determining benefits payable, charges made for the treatment of biologically-based mental disorders, rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to commit rape, or nonbiologically-based mental, behavioral or emotional disorders of children or adolescents under age 19 are not considered Mental Health Services but are payable on the same basis as for any other Sickness.

Substance Use Disorder is considered a biologically-based mental disorder as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the DSM).

Inpatient Services

Inpatient Services are services that are provided on a 24-hour basis while you or your Dependent is Confined in a general Hospital, a facility under the direction of the Department of Mental Health, a private mental Hospital licensed by the Department of Mental Health, or a substance use disorder facility licensed by the Department of Public Health for the treatment and evaluation of Mental Health.

Intermediate Services

Intermediate Services are a range of non-Inpatient Services that provide more intensive and extensive treatment interventions when outpatient services alone are insufficient to meet a patient's needs. Intermediate Services include, but are not limited to, the following (as defined by Massachusetts law):

- Acute and other residential treatment.
- Clinically managed detoxification services.
- Partial hospitalization.
- Intensive Outpatient Programs (IOP).
- Day treatment.
- Crisis stabilization.
- In-home therapy services.

Outpatient Services

Outpatient Services are services provided in person in an ambulatory care setting. Outpatient services may be provided in a licensed Hospital, a mental health or substance abuse clinic licensed by the Department of Public Health, a public community mental health center, a professional office, or home-based services. Such services delivered in such offices or settings are to be rendered by a licensed mental health professional (a licensed Physician who specializes in the practice of psychiatry; a licensed Psychologist; a licensed independent clinical social worker; a mental health counselor; or a licensed nurse mental health clinical specialist) acting within the scope of his or her license.

Exclusions

The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

HC-COV555 10-16
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External Prosthetic Appliances and Devices

Scalp Hair Prostheses

Scalp hair prosthesis worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia, if such coverage is in accordance with a written statement by a Physician that the prosthesis is Medically Necessary.

HC-COV84 04-10
V1-ET

Covered Expenses

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs, approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory

tests; sperm washing or preparation; artificial insemination and intrauterine insemination (IUI); diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization and embryo transfer (IVF-ET); sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurance (if any); intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility; zygote intrafallopian transfer (ZIFT); assisted hatching; cryopreservation of eggs; and the services of an embryologist.

Infertility is defined as the condition of an individual who is unable to conceive or produce conception during a period of one year for a female who is age 35 or younger, or during a period of 6 months for a female over age 35. If a person conceives, but is unable to carry that pregnancy to live birth, the period of time a woman attempted to conceive prior to achieving that pregnancy will be included in the calculation of the one year or 6 month period, as applicable. This benefit includes diagnosis and treatment of both male and female infertility.

However, donor charges and services are specifically excluded infertility services.

HC-COV471 06-15
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Short-Term Rehabilitative Therapy and Chiropractic Care Services

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

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

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

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

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

The following are specifically excluded from Chiropractic Care Services:

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

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

HC-COV86 04-10
V1-ET

Termination of Insurance – Continuation

Medical Insurance for Former Spouse

A covered former spouse is entitled to continue coverage following a final court decree granting divorce or separate support, until the earliest of the following:

- the date you fail to make any required contribution;
- the date you are no longer insured under the group policy;
- the date Dependent Insurance cancels;
- the date your former spouse remarries;
- the date you remarry, unless you make arrangements with the Employer to continue the insurance in accordance with the paragraph below entitled "Effect of Remarriage of Employee";
- the date the court judgment no longer requires continued coverage.

Effect of Remarriage of Employee

If you remarry, an additional contribution will be required for your former spouse. You must notify your Employer of your remarriage within 30 days of the date of your remarriage and pay the additional contribution.

Special Continuations of Medical Insurance

If your Medical Insurance terminates for the reason listed below, the Medical Insurance for you and your Dependents may be continued as outlined.

Involuntary Layoff

Medical Insurance for you and your Dependents will be continued until the earlier of: 39 weeks from the date your Active Service ends, or as shown in (1), (2) or (3) of the "Other Dates of Termination" section; upon payment of the required premium by you to your Employer.

Plant Closing

In the case of a plant closing, or a partial closing as determined by law, the Medical Insurance for you and your Dependents will be continued until the earlier of: 90 days from the date your Active Service ends; or as shown in (1), (2), or (3) of the "Other Dates of Termination" section. For continuation to take effect: you must continue to pay any portion of the premium for which you were responsible prior to the end of your Active Service; and your Employer must continue to pay any portion of the premium for which he was responsible before the plant closing or partial closing. If the insurance terminates because your Employer fails to pay the premium, he will be liable for any Covered Expenses incurred between the last premium payment and the end of the 90-day continuation period.

Any current collective bargaining agreement with an extension at least equal to the continuation outlined here, will prevail.

After Your Death

Medical Insurance for your Dependents will be continued until the earliest of: 39 weeks from the date your insurance ceases, or as shown in (2), or (3) of the "Other Dates of Termination" section, if the required payment is made to the Employer.

Other Dates of Termination

(1) The date you become eligible for Medical Insurance under any other group policy or Medicare;

(2) The last day of a period equal to the most recent time period during which you were insured under the Employer's policy, or, in the case of Dependent Medical Insurance continuation, a period equal to the most recent time period during which you were insured for your Dependents under the Employer's policy;

(3) With respect to any one Dependent, the earlier of: the date that Dependent becomes eligible for Medical Insurance under another group policy or under Medicare, or the date that Dependent no longer qualifies as a Dependent for any reason other than your death.

Special 31-Day Continuation

Upon payment of premium by your Employer, your insurance will continue for 31 days after you:

- cease to be in a Class of Eligible Employees or cease to qualify as an Employee.
- terminate employment for any reason.

In no case will the insurance continue after you become insured under any other group policy for similar benefits or after the last day for which you have made any required contribution for the insurance.

HC-TRM18 04-10

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Definitions

Dependent

Dependents include:

- your former spouse, unless the divorce decree provides otherwise.

A child includes:

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

HC-DFS968 10-16

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

CERTIFICATE RIDER – Minnesota Residents

Rider Eligibility: Each Employee who is located in Minnesota

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 Minnesota group insurance plans covering

insureds located in Minnesota. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETMNRDR

Special Plan Provisions

NOTICE:

MN Statute Section 60A.084 (2000) provides as follows: An Employer providing life or health benefits may not change benefits, limit coverage, or otherwise restrict participation until the certificate holder or enrollee has been notified of any changes, limitations, or restrictions. Notice in a format which meets the requirements of ERISA USCA, Title 29, Sections 1001-1461 is satisfactory for compliance with this section.

HC-SPP54 05-18
ET

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

Any Dependent child, or grandchild who is financially dependent upon you and who resides with you continuously from birth, born while you are insured, will become insured on the date of his birth. If additional premium is required, you are encouraged to pay the required premium no later than 31 days after the child or grandchild's birth. If additional premium is required and you do not elect to insure your newborn child or dependent grandchild within such 31 days, Cigna may reduce the health benefits owed by the amount of the past due premium.

HC-ELG193 01-18
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Certification Requirements - Out-of-Network

Mental health treatment covered under the plan which is court-ordered by a Minnesota court of competent jurisdiction pursuant to a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment, shall be covered without being subject to Pre-Admission Certification (PAC). A copy of the court order and behavioral care evaluations must be provided to the Plan. (Minn. Stat. 62Q.535)

HC-PAC64 11-15
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Prior Authorization/Pre-Authorized

Mental health treatment covered under the plan which is court-ordered by a Minnesota court of competent jurisdiction pursuant to a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment, shall be covered without being subject to prior authorization. A copy of the court order and behavioral care evaluations must be provided to the Plan. (Minn. Stat. 62Q.535)

HC-PRA37 11-16
ET-V1

Covered Expenses

- charges made for routine procedures for cancer screening, including mammograms, Papanicolaou tests, colorectal screening tests for men and women, and ovarian cancer screening for women considered at risk due to a prior positive test for BRCA1 or BRCA2 mutations; or a family history of: one or more first or second degree relatives with ovarian cancers; clusters of women relatives with breast cancer; or nonpolyposis colorectal cancer.
- charges for general anesthesia and for associated Hospital or facility charges for dental care for your Dependent child who is under the age of five (5) or who is severely disabled, or who has a medical condition and requires hospitalization or general anesthesia for dental care treatment. Pre-authorization of hospitalization is required. Coverage may also include general anesthesia and treatment provided by a licensed Dentist for a covered medical condition, regardless if the services are provided in a Hospital or in a dental office.

Clinical Trials

This benefit plan covers routine patient care costs related to an approved Phase I, II, III or IV clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to prevention, detection or treatment of cancer or other life-threatening disease or condition; and

(b) either
- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

- The study or investigation must:
  - be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
  - be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
  - involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

- the investigational drug, item, device, or service that is part of the trial itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If your plan includes In-Network providers, clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

- there are no In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual's state of residence.

HC-COV702 01-18

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Prescription Drug Benefits

Your Payments

Any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded and Cigna or its Review Organization approves as Medically Necessary shall be covered at the applicable coverage tier as set forth in The Schedule.

The amount you or your Dependent pays for any excluded Prescription Drug Product or other product or service will not be included in calculating any applicable plan Out-of-Pocket Maximum. You are responsible for paying 100% of the cost (the amount the Pharmacy charges you) for any excluded Prescription Drug Product or other product, and any negotiated Prescription Drug Charge will not be available to you.

Cigna shall approve coverage for an antipsychotic Prescription Drug Product not listed on the Prescription Drug List that is prescribed to treat an emotional disturbance or mental illness, as defined by 62Q.527 of the Minnesota Insurance Code, if the Physician prescribing such Prescription Drug Product:

- indicates to the dispensing pharmacist that the Prescription Order or Refill must be dispensed as communicated; and
- certifies in writing Cigna or its Review Organization that the Physician has considered all equivalent Prescription Drug Products on the Prescription Drug List and has determined that the Prescription Drug Product prescribed will best treat the enrollee's condition.

However, Cigna shall not be required to approve coverage for an antipsychotic Prescription Drug Product if the Prescription

Drug Product was removed from the Prescription Drug List for safety reasons.

HC-PHR264 01-18
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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 another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault or similar coverage.

The plan's subrogation right applies only after the Participant has received a full recovery from another source.

The plan's subrogation right is subject to subtraction for actual monies paid to account for the pro rata share of the Participant's costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless the plan is separately represented by an attorney. If the plan is separately represented by an attorney, the plan and the Participant, by their attorneys, may enter into an agreement regarding allocation of the Participant's costs, disbursements, and reasonable attorney fees and other expenses. If the plan and Participant cannot reach agreement on allocation, the plan and Participant shall submit the matter to binding arbitration.

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.

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 of any benefits paid under the plan. 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 of the benefits provided by the plan.

Cigna's claim rights under this provision will be valid only if you are fully compensated for your loss. Your costs, disbursements, attorney fees and other expenses incurred to obtain recovery from the third party will be subtracted from the amount of Cigna's claim right.

Additional Terms

- 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 pursuing any subrogation or recovery rights by providing requested information.

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Termination of Insurance

Employees

Termination of Insurance

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance;
- the last day for which you have made any required contribution for the insurance;
- the date the policy is canceled;
- the date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Special Continuation of Medical and Dental Insurance

If your Medical and Dental Insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you may continue the insurance by paying the required premium to the Employer. The insurance may be continued until the earliest of:

- 18 months from the date your Active Service ends;
- the last day for which you have paid the required premium;
- the date you become eligible for insurance under another group policy for medical or dental benefits, including Medicare, unless you have a pre-existing condition for which the new policy limits coverage, in which case coverage under this Plan will continue until the pre-existing condition limitation has been satisfied, unless coverage under this Plan otherwise ends in accordance with this section;
- the date the policy cancels;
- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.

Termination of Insurance

Dependents

Your insurance for all of your Dependents will cease on the earliest date below, except in the event of your death (Refer to the section titled Dependent Insurance After Your Death):

- the date your insurance ceases;
- the date you cease to be eligible for Dependent Insurance;
- the last day for which you have made any required contribution for the insurance;
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

For Dependents of Deceased Employee

If you die while insured for your Dependents, the insurance for your Dependents will be continued in accordance with the "Dependent Medical or Dental Insurance After Your Death" provision.

Dependent Medical, Medical with Vision, Medical with Prescription Drug Insurance After Your Death

If you are insured for Medical, Medical with Vision or Medical with Prescription Drug Insurance when you die, any of your Dependents who are then insured for such insurance, except a Dependent who is eligible for Medicare, will remain so insured without further payment of premiums for them. The insurance on any of those Dependents will remain in force until the earliest date below:

- the date that Dependent ceases to qualify as a Dependent for a reason other than lack of primary support by you;
- the date the surviving spouse becomes eligible under another group health plan.

The Dependent benefits payable after you die will be those in effect for your Dependents on the day prior to your death.

If the Dependents elect to continue the insurance beyond the last day of the "Dependent Medical or Dental Insurance After Your Death" provision, they must notify the Employer within 90 days of your death and pay the required premium. Such continued insurance will cease on the earliest date below:

- the date coverage ends due to the Dependents' failure to make payment of the required premium;
- the date the insurance for your Dependents would have ceased if you had not died;
- the date the Dependent ceases to qualify as a Dependent, except as provided in the "Continuation for Dependent Children" provision;
- the date the Dependent becomes insured under another group health plan, including Medicare, except as provided in the "Continuation for Dependent Children" provision;
- the date the policy cancels.

Dependent Medical Insurance After Divorce or Legal Separation

The Medical and Dental Expense Insurance for:

- your insured spouse; and
- any insured child who would cease to qualify as your Dependent as a result of your divorce or legal separation;

may be continued, with premium payment, if you are required by decree to provide continued Medical and Dental Expense Insurance for them. However, the insurance on those Dependents will cease on the earliest date below:

- the date coverage ends due to your failure to make payment of the required premium;

- the date your insurance ceases;
- the date your Dependent ceases to qualify as a Dependent, other than due to the spouse's remarriage;
- the date Dependent Insurance is canceled.

To have Dependent Medical and Dental Insurance continued, you must notify the Employer of the decree and pay any required contribution to the Employer within 30 days after the Dependent Medical Insurance would otherwise cease.

If you die, any other terms which continue Dependent Medical and Dental Insurance after your death will apply.

The Continuation for Dependent Children provision will be available when this Dependent Medical and Dental Insurance ceases.

Continuation for Dependent Children

If your Dependent child's insurance would otherwise cease because:

- you become eligible for Medicare; or
- the Dependent ceases to qualify as a Dependent;

such Dependent may continue his insurance by paying the required premium to the Employer.

The insurance may be continued until the earliest of:

- 36 months from the date your Dependent's insurance would otherwise cease;
- the date your Dependent becomes insured under another group policy for medical and dental benefits, including Medicare;
- the date insurance ends due to your Dependent's failure to make payment of the required premium; or
- the date the policy cancels.

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Medical Benefits Extension During Hospital Confinement 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 Confined in a Hospital on that date, Medical Benefits will be paid without requirement of premium for Covered Expenses incurred in connection with that Hospital Confinement. 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 plan; or
- the date you or your Dependent is no longer Hospital Confined;

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when your or your Dependent's Medical Benefits cease.

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Definitions

Medically Necessary/Medical Necessity

For mental health services, Medically Necessary/Medical Necessity means health care services appropriate, in terms of type, frequency, level, setting, and duration, to your diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

- help restore or maintain the enrollee's health; or
- prevent deterioration of the enrollee's condition.

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

CERTIFICATE RIDER – Missouri Residents

Rider Eligibility: Each Employee who is located in Missouri

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

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

The provisions set forth in this rider comply with the legal requirements of Missouri group insurance plans covering insureds located in Missouri. These provisions supersede any

provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

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Missouri First Steps Program

Cigna participates in Missouri's Part C Early Intervention System, "First Steps." "First Steps" provides coverage for Early Intervention Services described in this section that are delivered by early intervention specialists who are health care professionals licensed by the state of Missouri and acting within the scope of their professions for children from birth to age three identified by the Part C Early Intervention System as eligible services for persons under Part C of the Individuals with Disabilities Education Act.

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

Missouri Utilization Review Decisions and Procedures.

For initial determinations, Cigna shall make the determination within two working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

- In the case of a determination to certify an admission, procedure or service, Cigna shall notify the provider rendering the service by telephone or electronically within 24 hours of making the initial certification, and provide written or electronic confirmation of a telephone or electronic notification to the covered person and the provider within two working days of making the initial certification;
- In the case of an adverse determination, Cigna shall notify the provider rendering the service by telephone or electronically within 24 hours of making the adverse determination; and shall provide written or electronic confirmation of a telephone or electronic notification to the covered person and the provider within one working day of making the adverse determination.

For concurrent review determinations, Cigna shall make the determination within one working day of obtaining all necessary information:

- In the case of a determination to certify an extended stay or additional services, Cigna shall notify by telephone or electronically the provider rendering the service within one working day of making the certification, and provide written or electronic confirmation to the covered person and the provider within one working day after telephone or electronic notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;
- In the case of an adverse determination, Cigna shall notify by telephone or electronically the provider rendering the service within twenty-four hours of making the adverse determination, and provide written or electronic notification to the covered person and the provider within one working day of a telephone or electronic notification. The service shall be continued without liability to the covered person until the covered person has been notified of the determination.

For retrospective review determinations, Cigna shall make the determination within thirty working days of receiving all necessary information. Cigna shall provide notice in writing of Cigna's determination to a covered person within ten working days of making the determination.

When conducting utilization review or making a benefit determination for emergency services, Cigna shall cover emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services. When a covered person receives an emergency service that requires immediate post evaluation or post stabilization services, Cigna shall provide an authorization decision within 60 minutes of receiving a request; if the authorization decision is not made within 30 minutes, such services shall be deemed approved.

A written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination. Cigna shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to any party who received notice of the adverse determination and who requests such information.

Cigna shall have written procedures to address the failure or inability of a provider or a covered person to provide all

necessary information for review. In cases where the provider or a covered person will not release necessary information, Cigna may deny certification of an admission, procedure or service.

If an authorized representative of Cigna authorizes the provision of health care services, Cigna shall not subsequently retract its authorization after the health care services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition, the health benefit plan terminates before the health care services are provided or the covered person's coverage under the health benefit plan terminates before the health care services are provided.

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

Any Dependent child born while you are insured will become insured from the moment of his birth. The coverage for a newly born child shall consist of coverage for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. You must notify Cigna of the birth of the newly born child and pay any premium, if required, within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period. If an application or other form of enrollment is required by your Employer in order to continue coverage beyond the 31-day period after the date of birth, and you have notified Cigna of the birth, either orally or in writing, Cigna will, upon notification, provide you with all forms and instructions necessary to enroll the newly born child and will allow you an additional 10 days from the date the forms and instructions are provided in which to enroll the newly born child. If you do not notify Cigna of the birth of the newly born child and pay any premium, if required, within such 31 days, coverage for that child will end on the 31st day, and no benefits for expenses incurred beyond the 31st day will be payable.

Important Information About Your Medical Plan

Direct Access for OB/GYN Services

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

Direct Access for Chiropractic Care Services

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

Covered Expenses

- charges made for or in connection with mammograms for breast cancer screening or for diagnostic purposes for: one baseline mammogram for women age 35 but less than 40; a mammogram for women age 40 but less than 50, every two years or more frequently based on the recommendation of the patient's Physician; a mammogram every year for women age 50 and over; and a mammogram for women upon the recommendation of a Physician if the woman, her mother, or her sister has a prior history of breast cancer.
- charges made for prescription orally administered anticancer medications that are used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected anticancer medications. Coverage of orally administered anticancer medication shall not be subject to any prior authorization, dollar limit, Copayment, Deductible, or other out-of-pocket expense that does not apply to intravenously administered or injected anticancer medication, regardless of formulation or benefit category determination by Cigna.
- charges for a drug that has been prescribed as Medically Necessary to treat an illness for which it has not been approved by the Food and Drug Administration (FDA). Such a drug must be covered provided: it is recognized in an established reference compendia such as the United States Pharmacopeia Drug Information, American Hospital Formulary Service, or any peer-reviewed medical literature: for the specific type of illness for which it has been prescribed or the drug has not been contraindicated by the FDA for the use prescribed.
- charges made by a Hospital or an Ambulatory Surgical Facility for anesthesia for inpatient Hospital dental procedures for: a child under the age of five; a person with a severe disability; or a person with a behavioral or medical condition that requires hospitalization or general anesthesia when dental care is provided in a participating hospital, surgical center or office. Cigna may require prior authorization for hospitalization for dental procedures.

- charges for immunizations (including the associated office visit) for children from birth to 5 years of age as provided by department of health and senior services regulations . This includes the office visit in connection with immunizations. There will be no Deductible and no copay.
- charges for or in connection with human leukocyte antigen testing, or histocompatibility locus antigen testing for A, B, and DR antigens for utilization in bone marrow transplantation when performed in a facility accredited by the American Association of Blood Banks or its successors, the College of American Pathologists, the American Society for Histocompatibility and Immunogenetics or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is licensed under the Clinical Laboratory Improvement Act.
- charges for or in connection with the diagnosis, treatment and appropriate management of osteoporosis for persons with a condition or medical history for which bone mass measurement is Medically Necessary, provided such services are received by a Physician licensed to practice medicine and surgery in Missouri.
- charges for a colorectal examination and laboratory tests for cancer in accordance with current American Cancer Society guidelines for any nonsymptomatic person covered under the Plan.
- charges for a pelvic examination and Pap smear in accordance with current American Cancer Society guidelines for any nonsymptomatic woman covered under the Plan.
- charges for telehealth (telemedicine) will be covered on the same basis as covered services provided through a face to face consultation or contact with Participating Provider. Coverage does not include telehealth site origination fees or costs for the provision of telehealth services. Utilization may be utilized to determine the appropriateness of telehealth as a means of delivering a health care service on the same basis as when the same services is delivered in person.
- charges for prostate cancer examinations and laboratory tests for any insured nonsymptomatic male, in accordance with current American Cancer Society guidelines. Men age 50 and older should discuss getting an annual PSA blood test and a digital rectal exam with their Physician. Men who are at risk, which includes African American or men who have a family history of prostate cancer, should consider being tested at a younger age.
- charges made by a Hospital or other facility that provides obstetrical care for inpatient Hospital services will include Covered Expenses for a mother and her newborn child for 48 hours following a vaginal delivery or for 96 hours following a cesarean delivery. A longer stay will be covered if deemed Medically Necessary. The mother may request an earlier discharge if, after consulting with her Physician, it is determined that less time is needed for recovery. If discharged early, at least 2 post discharge visits will be covered, one of which will be a home visit by either a registered Nurse with experience in maternal and child health nursing or a Physician. These visits will include, but are not limited to, a physical assessment of the mother and the newborn; parent education; assistance and training in breast and bottle feeding; education and services for complete childhood immunizations; Medically Necessary clinical tests; and the submission of a metabolic specimen to the state laboratory.

Autism Spectrum Disorder and Applied Behavior Analysis

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

The terms used above are defined as follows:

- **Autism spectrum disorders** means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- **Diagnosis of autism spectrum disorders** means Medically Necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder.
- **Treatment for autism spectrum disorders** means care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed Physician or licensed Psychologist, including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician's or licensed Psychologist's license, including, but not limited to: psychiatric care; psychological care; habilitative or rehabilitative care, including applied behavior analysis therapy; therapeutic care; and pharmacy care.

- **Autism service provider** means any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst.
- **Applied behavior analysis** means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.
- **Habilitative or rehabilitative care** is professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual.
- **Line therapist** means an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.
- **Pharmacy care** means medications used to address symptoms of an autism spectrum disorder prescribed by a licensed Physician, and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications, only to the extent that such medications are included in the insured's health benefit plan.
- **Psychiatric care** means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- **Psychological care** means direct or consultative services provided by a Psychologist licensed in the state in which the Psychologist practices.
- **Therapeutic care** means services provided by licensed speech therapists, occupational therapists, or physical therapists.

Diagnosis and Treatment of Eating Disorders

Coverage is provided for the diagnosis and treatment of eating disorders when Medically Necessary, in accordance with a treatment plan. Medical Necessity determinations and care management shall consider the overall medical and mental health needs and not be based solely on weight, and shall take into consideration the most recent Practice Guidelines for the Treatment of Patients with Eating Disorders adopted by the American Psychiatric Association in addition to current standards based upon the medical literature generally recognized as authoritative in the medical community.

The terms used above are defined as follows:

- **Eating disorder**, Pica, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder, Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Other Specified Feeding or Eating Disorder, and any other eating disorder contained in the most recent version of the DSM of Mental Disorders published by the American Psychiatric Association where diagnosed by a licensed Physician, psychiatrist, Psychologist, clinical social worker, licensed marital and family therapist, or professional counselor duly licensed in the state where he or she practices and acting within their applicable scope of practice in the state where he or she practices;
- **Treatment of eating disorders**, therapy provided by a licensed treating Physician, psychiatrist, Psychologist, professional counselor, clinical social worker, or licensed marital and family therapist pursuant to the powers granted under such licensed Physician's, psychiatrist's, Psychologist's, professional counselor's, clinical social worker's, or licensed marital and family therapist's license in the state where he or she practices for an individual diagnosed with an eating disorder.

Clinical Trials

Charges made for routine patient services incurred as the result of the phase II, III, or IV of a clinical trial that is associated with the prevention, early detection, or treatment of cancer.

Phase III and IV of a clinical trial must be approved by one of the following entities:

- one of the National Institutes of Health (NIH);
- an NIH Cooperative Group or Center;
- the FDA in the form of an investigational new drug application;
- the federal Departments of Veterans' Affairs or Defense;
- an institutional review board in the State of Missouri that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CRF 46); or
- a qualified research entity that meets the criteria for NIH Center support grant eligibility.

Phase II of a clinical trial the clinical trial must be:

- approved by the National Institutes of Health (NIH), or
- approved by the National Cancer Institute Center, and be conducted at an academic or National Cancer Institute Center.

Additionally, the person must be actually enrolled in the clinical trial and not just applying the clinical trial protocol for Phase II.

Covered Expenses include drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the patient's particular condition, including coverage for reasonable and Medically Necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

Routine patient services shall include coverage for reasonable and Medically Necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient services include all items and services that are not otherwise generally available to a qualified individual that are provided in the clinical trial except:

- the investigational item, service or supply itself;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management of the patient; and
- items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Chiropractic Care Services

Charges made for the science and art of examination, diagnosis, adjustment, manipulation and treatment both in inpatient and outpatient settings, by those methods commonly taught in any chiropractic college or chiropractic program in a university which has been accredited by the Council on Chiropractic Education, its successor entity or approved by the board. It shall not include the use of operative surgery, obstetrics, osteopathy, podiatry, nor the administration or prescribing of any drug or medicine nor the practice of medicine.

The practice of chiropractic may include meridian therapy/acupressure/acupuncture with certification as required by the board.

A copayment that exceeds fifty percent of the total cost of providing any single chiropractic service to a covered person will never be imposed.

Covered Expenses

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 nondiseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. These benefits will be provided at any time following the mastectomy and will be paid the same as for any other illness. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

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, noncosmetic 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. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

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 is Entitled to Convert, and only if he 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, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- you have timely paid all required premium or contribution.
- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- the group policy terminated and the insurance is replaced by similar coverage under another group policy within 31 days of the date of termination.
- you are not eligible for Medicare.
- you are not or could not be covered for similar benefits by another individual policy; or you are not or could not be covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured; or similar benefits are not provided to or

available to you, by reason of any state or federal law, which result in you being Overinsured.

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

Any Dependent covered by the group policy on the date of termination of insurance is entitled to convert, but only if that Dependent has timely paid all required premium or contribution; is not eligible for Medicare; and would not be Overinsured.

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

The Converted Policy will be one of Cigna's current offerings at the time the first premium is received based on its rules for Converted Policies. The Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where you reside, if a Converted Policy is permitted by such jurisdiction, and there is no alternative state program available.

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, 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.

Prescription Drug Benefits

Covered Expenses

Your plan provides benefits for Prescription Drug Products dispensed by a Pharmacy. Prescription Drug Products include prescribed orally administered anticancer medications. Details regarding your plan's Covered Expenses, Limitations and Exclusions are provided below and are shown in The Schedule**.**

Termination of Insurance

Special Continuation of Medical Insurance

For Dependents of Deceased Employee

If you die while insured, your Dependents who are insured at the time of your death may continue their insurance by paying the required contribution to the Policyholder, but in no event beyond the earliest of the following dates:

- the expiration of 9 months from the date of your death;
- the last day of the period for which the required contribution has been paid;
- the date your insurance would otherwise have terminated as provided in the Special Continuation of Medical Insurance For Employees section;
- with respect to any one Dependent, the date that Dependent becomes eligible for similar group coverage;
- the date this policy cancels.

Definitions

Emergency Services

Emergency services are health care items or services furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider.

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

CERTIFICATE RIDER – Montana Residents

Rider Eligibility: Each Employee who is located in Montana

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

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Covered Expenses

- charges made by a Hospital for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following delivery by cesarean section for a mother and newborn infant.
- charges for one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;
- charges for a mammogram every 2 years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's Physician; and
- charges for a mammogram each year for a woman who is 50 years of age or older.
- charges made for well-child care benefits for Dependent children from birth through age seven. Coverage must include a history, physical examination, developmental assessment and anticipatory guidance as published by the American Academy of Pediatrics, laboratory tests and routine immunizations according the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. Department of Health and Human Services for immunization against: diphtheria; haemophilus influenzae type b; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; rotovirus; and any other immunization that is required by law for a child. Services must be provided during the course of one visit by or under the supervision of a single provider.
- charges made for acupuncture/acupressure when medically appropriate for the treatment of an illness or Injury.

Autism

Charges for diagnosis and treatment of autism spectrum disorders for a covered child 18 years of age or younger. Coverage must be provided to a child who is diagnosed with one of the following disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

- autistic disorder;
- Asperger's disorder; or
- pervasive developmental disorder not otherwise specified.

Coverage under this section includes:

- habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed Physician or licensed Psychologist, including but not limited to professional, counseling, and guidance services and treatment programs that are Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child;
- medications prescribed by a Physician licensed under Title 37, chapter 3;
- psychiatric or psychological care; and
- therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist licensed in this state.

Habilitative and rehabilitative care includes Medically Necessary interactive therapies derived from evidence-based research, including applied behavior analysis, which is also known as Lovaas therapy, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

Applied behavior analysis covered under this section must be provided by an individual who is licensed by the behavior analyst certification board or is certified by the Department of Public Health and Human Services as a family support specialist with an autism endorsement.

When treatment is expected to require continued services, Cigna may request that the treating Physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is Medically Necessary. The treatment plan must be based on evidence-based screening criteria. Cigna may ask that the treatment plan be updated every 6 months.

As used in this section, "Medically Necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a Physician or Psychologist licensed in this state and that will or is reasonably expected to:

- prevent the onset of an illness, condition, Injury, or disability;
- reduce or improve the physical, mental, or developmental effects of an illness, condition, Injury, or disability; or
- assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.
- coverage for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist. Coverage must include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.
- charges made for treatment of Biologically-Based Mental Illness. Such Covered Expenses will be payable the same as for other illnesses. Any mental illness maximums in the Schedule and any full payment area exceptions for mental illness will not apply to Biologically-Based Mental Illness.

Down Syndrome

Coverage for diagnosis and treatment of Down syndrome for a covered child 18 years of age or younger. Such coverage shall include habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed Physician, including but not limited to professional, counseling, and guidance services and treatment programs that are Medically Necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child; and Medically Necessary therapeutic care that is provided as follows:

- up to 104 sessions per year with a speech-language pathologist licensed pursuant to Title 37;
- up to 52 sessions per year with a physical therapist licensed pursuant to Title 37; and
- up to 52 sessions per year with an occupational therapist licensed pursuant to Title 37.

Habilitative and rehabilitative care includes Medically Necessary interactive therapies derived from evidence-based research, including intensive intervention programs and early intensive behavioral intervention. Benefits provided may not be construed as limiting physical health benefits that are otherwise available to the covered child.

When treatment is expected to require continued services, the insurer may request that the treating Physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is Medically Necessary. The treatment plan must be based on evidence-based screening criteria. The insurer may ask that the treatment plan be updated every 6 months.

As used in this section, "Medically Necessary" means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a Physician licensed in this state and that will or is reasonably expected to reduce or improve the physical, mental, or developmental effects of Down syndrome; or assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

Inborn Errors of Metabolism

Coverage for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist. Coverage must include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

Diabetes

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

- charges for Durable Medical Equipment, including podiatric appliances, related to diabetes. A special maximum will not apply.
- charges for insulin; syringes; injection aids, devises for self-monitoring of glucose levels (including those for the visually impaired), insulin pumps and accessories. Glucagon emergency kits, prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips; urine test strips; lancets; and alcohol swabs.

- charges for outpatient self-management training and education by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
  - Medically Necessary visits when diabetes is diagnosed;
  - visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
  - visits when reeducation or refresher training is prescribed by the Physician; and
  - medical nutrition therapy related to diabetes management.

Coverage for diabetes also includes screening for abnormal blood glucose as part of a cardiovascular risk assessment in adults aged 40 -70 who are overweight or obese.

Clinical Trials

This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

(b) either
  - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
  - the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

- the investigational drug, item, device, or service, itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If your plan includes In-Network providers, clinical trials conducted by non-Participating Providers will be covered at the In-Network benefit level if:

- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual's state of residence.

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Home Health Services

Home Health Services are provided only if Cigna has determined in advance that the home is a medically appropriate setting. In the case of a minor or an adult who is dependent on others for non-skilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided only when another family member or caregiver is present in the home to meet any needs for non-skilled care and/or custodial services.

Home Health Services are services that can be provided during home visits by other health care professionals. The services of a home health aide are covered when these services are in direct support of skilled health care services provided by other health care professionals. A visit is defined as a period of 2 hours or less. The Plan covers up to a maximum of 16 hours of Home Health Services per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered.

Home Health Services do not include services by a person who is a member of your family or your covered Dependent's family or who normally resides in your house or your covered Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services are not covered outside the home and are subject to the rules that apply to Home Health Services. Physical, occupational, and other short-term rehabilitative therapy services provided in the home are subject to the rules that apply to short-term rehabilitative therapy; they are not considered Home Health Services.

Home Health Care means services provided by a licensed home health agency to an insured in the insured's place of residence that is prescribed by the insured's attending Physician as part of a written plan of care. Services provided by Home Health Care include: nursing, home health aide services, physical therapy, occupational therapy, speech therapy, hospice service, medical supplies and equipment suitable for use in the home; and Medically Necessary personal hygiene, grooming, and dietary assistance.

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Mental Health and Substance Use Disorder Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Use Disorder.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Services are exchanged with Inpatient Mental Health Services at a rate of two days of Mental Health Residential Treatment being equal to one day of Inpatient Mental Health Treatment.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

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

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Partial Hospitalization or Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; autism spectrum disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment and Applied Behavior Analysis (ABA).

Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program in accordance with the laws of the appropriate, legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Use Disorder Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Residential Treatment services.

Substance Use Disorder Residential Treatment Services are services provided by a Hospital for the evaluation and

treatment of the psychological and social functional disturbances that are a result of subacute Substance Use Disorder conditions.

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorder Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, a group, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program.

Substance Use Disorder Partial Hospitalization services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Use Disorder Intensive Outpatient Therapy Program services are exchanged with Outpatient Substance Use Disorder services at a rate of one visit of Substance Use Disorder Intensive Outpatient Therapy being equal to one visit of Outpatient Substance Use Disorder Rehabilitation Services.

Substance Use Disorder Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- geriatric day care, occupational and recreational therapy for age related cognitive decline.
- special education, including but not limited to school tuition.
- counseling for educational reasons, IQ testing or other testing (including psychological testing on children requested by or for a school system).
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious training and counseling.
- cognitive rehabilitation.
- work-hardening programs.
- wilderness programs.
- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for borderline intellectual functioning.

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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 other breast to produce symmetrical appearance; 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.
- charges for Medically Necessary inpatient Hospital care following a mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer. The period of time for the hospitalization is to be determined by the Physician in consultation with the patient.

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Transplant Services

- charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

All Transplant services, other than cornea, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LIFESOURCE Transplant Network® facilities, are payable at the In-Network level.

Transplant services received at any other facilities, including non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are not covered.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation (refer to Transplant Travel Services), hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation and lodging are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); and lodging while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age. The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income; travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available when the covered person is a donor.

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Medical Pharmaceuticals

The Plan covers charges made for Medical Pharmaceuticals that are administered in an Inpatient setting, Outpatient setting, Physician's office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling. The following diabetic supplies are also covered under the plan's medical benefit: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (including one insulin pump for each warranty period), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to

try a different Medical Pharmaceutical and/or Prescription Drug Product first.

The Cigna Business Decision Team determines whether utilization management requirements or other coverage conditions should apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. When considering a Medical Pharmaceutical for a coverage status, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

HC-COV550 10-16

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.
- 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.

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Payment of Benefits

Assignment and Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

You may, however, authorize Cigna to pay any healthcare benefits under this policy to a Participating or non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for covered services directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the non-Participating Provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Recovery of Overpayment

- **(1)** Except as provided in subsection (3), (4), or (5), if a health insurance issuer limits the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer has the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim.
- **(2)** Except as provided in subsection (3), (4), or (5), if a health insurance issuer does not limit the time in which a health care provider or other person is required to submit a claim for payment, a health insurance issuer may not request reimbursement or offset another claim payment for

reimbursement of an invalid claim or overpayment of a claim more than 12 months after the payment of an invalid or overpaid claim.

- **(3)** Regardless of the period allowed by a health insurance issuer for submission of claims for payment, a health insurance issuer may perform a review or audit to reconsider the validity of a claim and may request reimbursement for an invalid or overpaid claim within 12 months from the date upon which the health insurance issuer received notice of a determination, adjustment, or agreement regarding the amount payable with respect to a claim by:
  - **(a)** Medicare;
  - **(b)** a workers' compensation insurer;
  - **(c)** another health insurance issuer or group health plan;
  - **(d)** a liable or potentially liable third party; or
  - **(e)** a foreign health insurance issuer under an agreement among plans operating in different states when the agreement provides for payment by the Montana health insurance issuer as host plan to Montana providers for services provided to an individual under a plan issued outside of the state of Montana.
- **(4)**
  - **(a)** The time limitations on the health insurance issuer in subsections (1) and (2) do not commence running until the time specified in subsection (4)(b) if a health insurance issuer pays a claim in which the health insurance issuer:
    - **(i)** suspects the health care provider or claimant of insurance fraud related to the claim; and
    - **(ii)** has reported evidence of fraud related to the claim to the commissioner pursuant to 33-1-1205.
  - **(b)** The time limitation commences running on the date that the commissioner determines that insufficient evidence of fraud exists.
- **(5)** The time limitations on the health insurance issuer in subsections (1) and (2) do not commence running until the health insurance issuer has actual knowledge of an invalid claim, claim overpayment, or other incorrect payment if the health insurance issuer has paid a claim incorrectly because of an error, misstatement, misrepresentation, omission, or concealment, other than insurance fraud, by the health care provider or other person. Regardless of the date upon which the health insurance issuer obtains actual knowledge of an invalid claim, claim overpayment, or other incorrect payment, this subsection does not permit the health insurance issuer to request reimbursement or to offset another claim payment for reimbursement of the claim more than 24 months after payment of the claim.

A health insurance issuer may not collect a claim overpayment or other reimbursement by offsetting another claim payment made to a health care provider or other person unless the health care provider or other person has previously authorized the health insurance issuer in writing to recover an overpayment or other reimbursement by offsetting a future claim payment.

Calculation of Covered Expenses

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

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

HC-POB119 10-16
ET

Termination of Insurance

Reduction in Work Schedule (for Medical Insurance)

If your insurance would otherwise cease due to a reduction of the number of hours in your regular work schedule, your insurance may be continued subject to all the other terms and conditions of the policy as long as you continue to be employed. Your insurance will not be continued past the date your Employer stops paying premium for you or otherwise cancels your insurance. Medical Insurance will not be continued for more than one year.

HC-TRM1 04-10
V4-ET

Definitions

Biologically-Based Mental Illness

A Biologically-Based Mental Illness is any of the following disorders, as defined by the American Psychiatric Association: schizophrenia; schizoaffective disorder; bipolar disorder; major depression; panic disorder; obsessive-compulsive disorder; and autism.

HC-DFS587 04-10
V1-ET

Dependent

Covered children include:

- a child from the moment of birth. Newborns are covered for 31 days before additional premiums, if any, are due.
- a legally adopted child including coverage from the date of preadoptive placement in your home.
- a child of your insured Dependent until the date your insured Dependent is no longer eligible for coverage.

Pre-existing coverage limitations and waiting periods do not apply to newborns or newly adopted children. Deductibles apply to newly acquired children only to the extent they apply to any other insured person.

HC-DFS414 01-11

V11-ET

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

CERTIFICATE RIDER – Nebraska Residents

Rider Eligibility: Each Employee who is located in Nebraska

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

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

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

HC-ETNERDR

Covered Expenses

- charges made for one screening test for hearing loss for a Dependent child from birth through 30 days old.
- charges for the screening, diagnosis, and treatment of autism spectrum disorder.

Treatment means evidence-based care, including related equipment that is prescribed or ordered for a covered person diagnosed with an autism spectrum disorder by a licensed Physician or a licensed Psychologist including: behavioral health treatment; pharmacy care; psychiatric care; psychological care; and therapeutic care.

Behavioral health treatment means counseling and treatment programs, including applied behavior analysis, that are: necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and provided by a certified behavior analyst or a licensed Psychologist if the services performed are within the boundaries of the Psychologist's competency.

Pharmacy care means a medication that is prescribed by a licensed Physician and any health related service deemed Medically Necessary to determine the need or effectiveness of the medication.

Psychiatric care means a direct or consultative service provided by a psychiatrist licensed in the state in which he or she practices.

Psychological care means a direct or consultative service provided by a Psychologist licensed in the state in which he or she practices.

Therapeutic care means a service provided by a licensed speech-language pathologist, occupational therapist, or physical therapist.

HC-COV674 01-18

ET

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

CERTIFICATE RIDER – Nevada Residents

Rider Eligibility: Each Employee who is located in Nevada

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 Nevada group insurance plans covering insureds located in Nevada. These provisions supersede any

provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNVRDR

Important Notices

Nevada Division of Insurance

You can contact the Nevada Division of Insurance at the following:

The Department of Business Industry, Division of Insurance

Toll free number: (888) 872-3234

Hours of operation of the division: Mondays through Fridays from 8:00 a.m. until 5:00 p.m., Pacific Standard Time (PST).

If you have local telephone access to the Carson City and Las Vegas offices of the Division of Insurance, you should call the local numbers.

Local telephone numbers are: Carson City, **702-687-4270** and Las Vegas, **702-486-4009**

HC-IMP48 04-10
V2-ET

Covered Expenses

- charges for a drug that has been prescribed for the treatment of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration if that drug has been recognized as a treatment for cancer by either the American Hospital Formulary Services Drug Information; US Pharmacopoeia Drug Information; or supported by at least two articles published in accepted scientific medical journals. Coverage will also be provided for any medical services necessary to administer the drug.

HC-COV677 12-17
ET

Definitions

If Domestic Partners are covered under the plan, then the following applies:

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

HC-DFS709 01-15
ET

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

CERTIFICATE RIDER – New Jersey Residents

Rider Eligibility: Each Employee who is located in New Jersey

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

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

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

HC-ETNJRDR

Important Notice

Your health plan provides that you will not be held financially liable for payments to health care providers for any sums, other than required copayments, coinsurance or deductibles, owed for covered expenses, if Cigna fails to pay for the covered expenses for any reason.

HC-IMP17 04-10
V1-ET

Covered Expenses

Covered Expenses include charges for childhood immunizations as recommended by the Advisory Committee on Immunization practices of the U.S. Public Health Service, the Department of Health and the New Jersey Department of Health and Senior Services for a Dependent child during that child's lifetime.

HC-COV670 12-17
ET

Payment of Benefits

Calculation of Covered Expenses

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

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

HC-POB108 01-17
ET

Definitions

Dependent

Dependents include:

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

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

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

HC-DFS978 01-17
ET

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies means or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury or disease.

HC-DFS113 04-10

V1-ET

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

CERTIFICATE RIDER – New Mexico Residents

Rider Eligibility: Each Employee who is located in New Mexico

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

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

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

HC-ETNMRDR

The Schedule

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

If you are enrolled in a Managed Medical plan which excludes Pharmacy provisions, the Medical Schedule is amended to indicate that a $10 copay shall apply for In-Network **Diabetic Medications**.

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."

SCHEDDENE-ET

Covered Expenses

- charges made for or in connection with mammograms for breast cancer screening and diagnosis, not to exceed: a baseline mammogram for women ages 35 to 39; and a mammogram every one to two years for women ages 40 to 49; and an annual mammogram for women age 50 and over.
- charges for Early Intervention Services, for or under the family, infant, and toddler program administered by the New Mexico Department of Health for eligible Dependents from birth through age 3 when provided as part of an individualized family services plan and delivered by licensed and certified Department of Health personnel.
- immunizations in accordance with the recommendations of the American Academy of Pediatrics (AAP).
- charges made by a Hospital for inpatient care for 48 hours following a mastectomy and for 24 hours following a lymph node dissection for treatment of breast cancer. The patient and Physician may determine if a shorter Hospital stay is appropriate.

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

- charges for Durable Medical Equipment, including: insulin pumps and accessories; insulin infusion devices and related accessories, including those adaptable for the legally blind; and glucometers and blood glucose monitors for the legally blind.
- charges for External Prosthetic Appliances, including custom foot orthotics. Coverage will be provided for podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment.

- charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
  - Medically Necessary visits when diabetes is diagnosed;
  - visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management; and
  - Medical Nutrition therapy related to diabetes management.
- new or improved equipment, appliances, and prescription drugs that are approved by the Food and Drug Administration.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).

Nutritional Evaluation and Counseling

Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes treatment of genetic inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist.

Coverage also includes expenses of diagnosing, monitoring and controlling disorders by nutritional and medical assessment, including clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

Genetic inborn error of metabolism means a rare, inherited disorder that: is present at birth; and if untreated, results in mental retardation or death; and causes the necessity for consumption of special medical foods.

Special medical foods means nutritional substances in any form that are:

- formulated to be consumed or administered enterally under the supervision of a Physician;
- specifically processed or formulated to be distinct in one or more nutrients present in natural food;
- intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and
- essential to optimize growth, health and metabolic stability.

Treatment means medical services provided by licensed Health Care Professionals, including Physicians, dieticians and nutritionists, with specific training in managing patients diagnosed with inborn errors of metabolism.

Coverage for enteral nutrition does not include:

- Regular grocery products that meet the nutritional needs of the patient (e.g. over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or
- Medical food products that:
  - are prescribed without a diagnosis requiring such foods;
  - are used for convenience purposes;
  - have no proven therapeutic benefit without an underlying disease, condition or disorder;
  - are used as a substitute for acceptable standard dietary intervention; or
  - are used exclusively for nutritional supplementation.

External Prosthetic Appliances and Devices

Foot Care

Services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that are administered in an Inpatient setting, Outpatient setting, Physician’s office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product’s FDA labeling. The following diabetic supplies are also covered under the plan’s medical benefit: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pumps accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, urine glucose and ketone strips.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug Product first.

The Cigna Business Decision Team determines whether utilization management requirements or other coverage conditions should apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. When considering a Medical Pharmaceutical for a coverage status, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

Definitions

Certification

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

Covered Person

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

Culturally and Linguistically Appropriate Manner of Notice

The term Culturally and Linguistically Appropriate Manner of Notice means:

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

Dependent

The term child means a child born to you or a child legally adopted by you from the start of any waiting period prior to the finalization of the child's adoption.

Grievant

The term Grievant means any of the following:

- A policyholder, subscriber, enrollee, or other individual, or that person's authorized representative or provider, acting on behalf of that person with that person's consent, entitled to receive health care benefits provided by Cigna;

- An individual, or that person's authorized representative, who may be entitled to receive health care benefits provided by Cigna;
- Medicaid recipients enrolled in a Cigna Medicaid plan, if Cigna offers such a plan.

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

Health Benefits Plan

The term Health Benefit Plan means a health plan or a policy, contract, certificate or agreement offered or issued by a Health Care Insurer or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of Health Care Services; this includes a Traditional Fee-For-Service Health Benefits Plan.

Health Care Insurer

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

Health Care Professional

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

Health Care Services

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

Hearing Officer, Independent Co-Hearing Officer or ICO

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

Medical Necessity or Medically Necessary

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

Provider

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

Rescission of Coverage

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

- the cancellation or discontinuance of coverage has only a prospective effect; or
- the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Summary of Benefits

The term Summary of Benefits means the written materials required by NMSA 1978 Section 59A-57-4 to be given to the Grievant by Cigna or group contract holder.

Termination of Coverage

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

Traditional Fee-For-Service Indemnity Benefit

The term Traditional Fee-For-Service Indemnity Benefit means a fee-for-service indemnity benefit, not associated with

any financial incentives that encourage Grievants to utilize preferred Providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to otherwise comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form of reimbursement for services.

Uniform Standards

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

Utilization Management Determinations

The term Utilization Management Determinations means the outcome, including Certification and adverse determination, of the review and evaluation of Health Care Services and settings for Medical Necessity, appropriateness, efficacy, and efficiency.

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

CERTIFICATE RIDER – New York Residents

Rider Eligibility: Each Employee who is located in New York

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

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

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

HC-ETNYRDR

Covered Expenses

- charges for enteral formulas, whether administered orally or via feeding tube, for home use for the treatment of: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and multiple, severe food allergies. The Physician must issue a written order stating that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for individuals who are or will become malnourished or suffer from disorders which, if left untreated, cause chronic physical disability, mental retardation or death. Covered expenses will also include modified solid food products that are low protein or which contain modified protein, which are Medically Necessary. Such coverage for any calendar year or continuous 12-month period will be limited to $2,500, applicable to Out-of-Network benefits only.

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HC-COV321 10-15
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Conversion Right To New Policy After Termination

You have the right to convert to a new Policy if coverage under this Certificate terminates under the circumstances described below.

- **Termination of the Group Policy.** If the Group Policy between Cigna and the Group Policyholder is terminated as set forth in the Policy, and the Group Policyholder has not replaced the coverage for the Group with similar and continuous health care coverage, whether insured or self-insured, you are entitled to purchase a new Policy as direct payment members.
- **If You Are No Longer Covered in a Group.** If your coverage terminates under this Certificate because you are no longer a member of a Group, you are entitled to purchase a new Policy as a direct payment member.

- **On the Death of the Employee.** If coverage terminates under this Certificate because of the death of the Employee, the Employee's Dependents are entitled to purchase a new Policy as direct payment members.
- **Termination of Your Marriage.** If a Spouse's coverage terminates under this Certificate because the Spouse becomes divorced from the Employee or the marriage is annulled, that former Spouse is entitled to purchase a new Policy as a direct payment member.
- **Termination of Coverage of a Child.** If a Dependent child's coverage terminates under this Certificate because the child no longer qualifies as a Dependent child, the child is entitled to purchase a new Policy as a direct payment member.
- **Termination of Your Temporary Continuation of Coverage.** If coverage terminates under this Certificate because you are no longer eligible for continuation of coverage, you are entitled to purchase a new Policy as a direct payment member.
- **Termination of Your Young Adult Coverage.** If a Dependent child's young adult coverage terminates under this Certificate, the child is entitled to purchase a new Policy as a direct payment member.

When to Apply for the New Contract. If you are entitled to purchase a new Policy as described above, you must apply to Cigna for the new Policy within 60 days after termination of coverage under this Certificate. You must also pay the first Premium of the new Policy at the time you apply for coverage.

The New Policy. Cigna will offer you an individual direct payment Policy at each level of coverage (i.e., bronze, silver, gold or platinum) that covers all benefits required by state and federal law. You may choose among any of the four Policies offered by Cigna. However, the coverage may not be the same as your current coverage. However, if Cigna determines that you do not reside in New York State, Cigna may issue you or your family members coverage on a form that we use for conversion in that state.

When Conversion is Not Available. Cigna will not issue you an individual direct payment Policy if the issuance of the new Policy will result in overinsurance or duplication of benefits according to the standards Cigna has on file with the Superintendent of the New York State Department of Financial Services.

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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

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

Newborns are automatically covered for the first 31 days after birth. In order to continue the child's coverage after the end of that 31-day period, you must elect to insure your newborn child within 31 days after the date of birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Court Ordered Children

- Either parent must be permitted to enroll court ordered children without any enrollment period restrictions.
- Employers must enroll court ordered children when parent does not.
- Either parent must be permitted to enroll court ordered dependent children living outside of the plan's approved service area.

HC-ELG187 12-17
ET

Covered Expenses

- charges made for or in connection with: an annual cytologic screening (Pap smear) for detection of cervical cancer; a single baseline mammogram for women ages 35 to 39; a mammogram every 2 years for women ages 40 through 49, or an annual mammogram if a licensed Physician has determined the woman to be at risk; and an annual mammogram for women ages 50 through 64. Screening mammography's can 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. The total benefit for a screening mammography shall not exceed 130% of the lowest Medicare reimbursement rate in Ohio for screening mammography. 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.
- charges for diagnostic and exploratory procedures to determine infertility, including surgical procedures to correct the medically diagnosed disease or condition of reproductive organs, including but not limited to endometriosis, collapsed/clogged fallopian tubes or testicular failure; in vitro fertilization, gamete intrafallopian transfer and zygote intrafallopian transfer are not covered.

Maternity

- charges for coverage for 48 hours of inpatient care following a vaginal delivery and 96 hours of inpatient care following a cesarean section for a mother and her newborn.
- any decision for early discharge (i.e. prior to the 48 or 96 hours) is to be made by the attending Physician or nurse mid-wife after conferring with the mother or person responsible for the mother or newborn.
- any length of stay beyond the 48 or 96 hours will be covered if determined Medically Necessary.

Inpatient care will include:

- medical services;
- educational services; and
- any other services that are consistent with protocols and guidelines developed by national pediatric, obstetric, and nursing professional organizations for these services (e.g. AAP/ACOG Guidelines).

Post-discharge Follow-up

- If a mother and newborn are discharged prior to the 48 or 96 hours, policies and contracts will also provide coverage for all Physician/advanced practice registered nurse-directed follow-up care provided during the first 72 hours after discharge. Coverage for follow-up care after that 72 hour period will be provided if the services are Medically Necessary.
- If a mother and newborn receive at least 48 or 96 hours of inpatient stay following a vaginal or cesarean section, respectively, then policies and contracts will provide coverage for follow-up care if it is determined Medically Necessary by the attending health care professionals.
- Coverage for follow-up care will apply to services provided in a medical setting (e.g. doctor's office or facility) or through home health care visits. Home health care visits must be conducted by a health care professional with knowledge and training in maternity and newborn care.

Follow-up services will include:

- physical assessment of the mother and newborn;
- parent education;
- assistance and training in breast and bottle feeding;
- assessment of the home support system;
- the performance of any Medically Necessary and appropriate clinical tests; and
- any other services that are consistent with protocols and guidelines developed by national pediatric, obstetric, and nursing professional organizations for these services (e.g. AAP/ACOG Guidelines).

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

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

- Require coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
- Require coverage for experimental drugs not approved for any indication by the FDA;
- Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the FDA;
- Require reimbursement or coverage for any drug not included in the drug formulary or list of covered drugs specified in the policy;
- Prohibit Cigna from limiting or excluding coverage of a drug, provided that the decision to limit or exclude coverage of the drug is not based primarily on the coverage of drugs described in this provision.

Clinical Trials

- Charges made for routine patient care administered to an insured person participating in any stage of an Eligible Cancer clinical trial if that care would be covered under the plan if the insured was not participating in the trial.

- Routine patient costs are generally defined as items and services that typically would be covered under the plan for an individual not enrolled in a clinical trial.
- An individual may qualify to participate in a clinical trial based on a referral from a participating health care professional or by providing medical and scientific information establishing that participation would be appropriate.
- "Approved clinical trial" is defined as a Phase I, Phase II, Phase III, or Phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. The clinical trial must be federally approved or funded by one of the designated entities in the statute (outlined below). Routine costs for Approved clinical trials are covered.
- The clinical trial must meet the following requirements; the study or investigation must meet 1, 2 or 3 below:
  1. Be approved or funded by:
     A. the National Institutes of Health;
     B. the Centers for Disease Control and Prevention;
     C. the Agency for Health Care Research on Quality;
     D. the Centers for Medicare & Medicaid Services;
     E. cooperative group or center of any of the entities named in (A) through (D); or the Department of Defense or the Department of Veterans Affairs;
     F. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
     G. any of the following if the "Conditions For Departments" are met:
        (i) The Department of Veterans Affairs.
        (ii) The Department of Defense.
        (iii) The Department of Energy.
  2. Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
  3. Involve a drug trial that is exempt from having such an investigational new drug application.

  Coverage for cancer clinical trials is subject to all terms, conditions, exclusions and limitations that apply to any other coverage under the plan for services performed by Participating and non-Participating Providers.

  Routine patient care means all health care services consistent with the coverage provided in the health benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial and that was not necessitated solely because of the trial.

  Routine patient care does not include, and reimbursement will not be provided for:
  - A health care service, item or drug that is the subject of the cancer clinical trial (i.e. the service, item or drug that is being evaluated in the clinical trial and that is not routine patient care);
  - A health care service, item or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
  - An investigational or experimental drug or device that has not been approved for market by the U.S. Food and Drug Administration;
  - Transportation, lodging, food or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
  - An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; or
  - A service, item or drug that is eligible for reimbursement by a person other than the carrier, including the sponsor of the cancer clinical trial.

HC-COV685 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 Network Pharmacies at 100% after deductible, if applicable and if applicable at non-Network Pharmacies, the same as the out of network medical cost share for injectable/IV chemotherapy.

SCHEDPHARM90-ohet

Prescription Drug Benefits

Limitations

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.

HC-PHR262 12-18
ET

Payment of Benefits

Recovery of Overpayment on a Provider Claim

A payment made by Cigna to a provider is considered final two years after payment is made. After that date, the amount of the payment is not subject to adjustment, except in the case of fraud by the provider.

Cigna may recover the amount of any part of a payment that we determine to be an overpayment to the provider if the recovery process is initiated not later than two years after the payment was made. Cigna must provide notice in writing and specify covered person's name, date of service, amount of overpayment, claim number, detailed explanation of basis for overpayment, method in which payment was made including the date of payment and check number.

Cigna must give the provider opportunity to appeal an overpayment determination. If the provider fails to respond within 30 days of receipt of notice, elects not to appeal, or appeals the determination but decision is upheld, Cigna may initiate overpayment recovery. Cigna can permit the provider to repay the overpaid amount or have the amount recouped.

This section does not apply in cases of fraud by the provider, the insured or member, or Cigna with respect to the claim on which the overpayment or underpayment was made.

HC-POB86 10-16
ET

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 on a direct-payment basis by Cigna only to a person who is Entitled to Convert, and only if he 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, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- 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 whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse 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 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

The Converted Policy will be one of Cigna's current offerings at the time the first premium is received based on its rules for Converted Policies. The Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where you reside, if a Converted Policy is permitted by such jurisdiction, and there is no alternative state program available.

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, 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.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. 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-CNV26
HC-CNV27 04-10
V1-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

Medical Benefits Extension

Coverage will continue to be provided while you are confined to a Hospital following termination of coverage. Coverage will be provided for the specific medical condition causing the confinement and any other Medically Necessary treatment during that period of confinement.

This extension of coverage will end on the earliest of the following:

- the date the insured is discharged from the Hospital;
- the date the insured's attending Physician determines that the Hospital Confinement is no longer Medically Necessary;
- the date the insured exhausts the coverage available for the confinement and/or medical condition; or
- the effective date of coverage for the insured under another policy, plan or contract.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when a person's benefits cease.

HC-BEX31 04-10
V1-ET

Definitions

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 or a child for whom you are the legal guardian.

HC-DFS828 10-16
ET

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

CERTIFICATE RIDER – Oregon Residents

Rider Eligibility: Each Employee who is located in Oregon

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

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

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

HC-ORM-04-11 HC-ETORRDR

Certification Requirements

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Any PAC determination will be binding on Cigna for:

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

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

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

HC-PAC4 11-14
V2-ET

Covered Expenses

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

HC-COV618 12-17
V1 ET1

Craniofacial Abnormalities

- charges made for dental and orthodontic services for the treatment of Craniofacial Anomalies if the services are Medically Necessary to restore function.

  Coverage does not include the treatment of:

  - developmental maxillofacial conditions that result in overbite, crossbite, malocclusion or similar developmental irregularities of the teeth; or
  - temporomandibular joint disorder.

  Craniofacial Anomaly means a physical disorder identifiable at birth that affects the bony structures of the face or head, including but not limited to cleft palate, cleft lip, craniosynostosis, craniofacial microsomia and Treacher Collins syndrome.

HC-COV248 10-16
ET

Definitions

Dependent

The term child means a child born to you or a child legally adopted by you including that child from the date of

placement. Coverage for such child will include the necessary care and treatment of medical conditions existing prior to the date of placement including medically diagnosed congenital defects or birth abnormalities. It also includes a stepchild.

HC-DFS1067 10-16
ET1

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

CERTIFICATE RIDER – 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

Eligibility - Effective Date

Employee Insurance

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 31 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 31 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

HC-ELG1 04-10
V8-ET

The Schedule

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."

SCHEDDENE-ET1

Covered Expenses

- charges made for Medically Necessary care and treatment of cleft lip and palate and any condition or illness which is related to or developed as a result of cleft lip and palate. This includes, but is not limited to oral/facial surgery, teeth capping prosthodontics, orthodontics, otolaryngology, and audiological care. If the procedures are also covered by a dental policy, medical benefits can be excluded for prosthodontics, including teeth capping, and orthodontics.
- charges for inpatient care for up to 48 hours after a vaginal delivery and up to 96 hours after a caesarean section for a mother and her newborn, payable as any other inpatient stay. The day of delivery or surgery will not count toward the length of stay. Any length of stay beyond the 48 or 96 hours will be covered if determined Medically Necessary. This does not prevent a mother and her newborn from being discharged earlier than the 48 or 96 hours if the mother and doctor agree to the earlier discharge.
- charges for mastectomy surgery to also provide coverage for prosthetic devices and reconstruction of the breast on which surgery for breast cancer has been performed and surgery and reconstruction of the non-diseased breast, if determined Medically Necessary by the patient's attending Physician with the approval of the insurer.
- charges made for at least 48 hours of inpatient care following a mastectomy. A shorter stay is acceptable when

ordered by the attending Physician. In the case of an early release, charges for at least one home care visit will be covered, if ordered by the Physician.

- charges for a mammogram: 1) once for women age 35 to 39; 2) once every two years for women age 40 to 49; and 3) once a year for women who are at least 50. Coverage must also be provided for an annual pap smear. Coverage must be provided for additional pap smears when recommended by a Physician.
- charges made for treatment of Autistic Disorder, Asperger's Syndrome, Pervasive Developmental Disorder - Not Otherwise Specified and ABA therapy. Coverage is limited to treatment that is prescribed by the insured's treating medical doctor in accordance with a treatment plan, to include a diagnosis, proposed treatment by type, frequency, and duration of treatment, the anticipated outcomes stated as goals, the frequency by which the treatment plan will be updated, and the treating medical doctor's signature.

HC-COV643 12-17
ET

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 is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to Cigna within 60 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, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- 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 60 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 whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death; (In the case of divorce, the former spouse must make written application and pay the required premium within 60 days after the entry of final decree.)
- 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 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

The Converted Policy will be one of Cigna's current offerings at the time the first premium is received based on its rules for Converted Policies. The Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where you reside, if a Converted Policy is permitted by such

jurisdiction, and there is no alternative state program available.

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, 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.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. 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-CNV1 04-10
V3-ET

Medical Benefits Extension

If the Medical Benefits under this plan cease for you or your Dependent 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;
- 12 months from the date your Medical Benefits cease; or
- 12 months from the date of termination.

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.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when you or your Dependent's Medical Benefits cease.

HC-BEX32 04-10
V1-ET

Definitions

Dependent

The term child means a child born to you or a child legally adopted by you, 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-DFS981 10-16
ET

Emergency Service/Emergency Medical Condition

Emergency Services are covered inpatient and outpatient services that are furnished by a qualified provider and are needed to evaluate or stabilize an Emergency Medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would result in one of the following:

- Placing the health of the individual, or with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;

- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

HC-DFS263 04-10
V1-ETC

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

CERTIFICATE RIDER – Tennessee Residents

Rider Eligibility: Each Employee who is located in Tennessee

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

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

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

HC-ETTNRDR

Covered Expenses

- charges for treatment of conditions or disorders of hearing, speech, voice or language if treatment is received from a licensed audiologist or speech pathologist.
- charges made for or in connection with a drug that has been prescribed for the treatment of a type of condition for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be covered, provided: it is recognized as medically appropriate for the treatment of the specific type of condition for which the drug has been prescribed in any one of the following reference compendia: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; United States Pharmacopeia Drug Information; or the drug is recommended by one review article in a U.S. peer-reviewed national professional journal; it has been otherwise approved by the FDA; its use for the specific type of treatment prescribed has not been contraindicated by the FDA.
- Telehealth means the use of real-time, interactive audio, video telecommunications or electronic technology, or store and forward telemedicine services by a healthcare provider to deliver services to a patient within the scope of practice of the provider when:
  - Such provider is at a qualified site other than the site where the insured is located; and
  - The insured is at a qualified site or a school clinic staffed by a healthcare provider and equipped to engage in telecommunications or at a public elementary or secondary school staffed by a healthcare provider and equipped to engage in telecommunications.

  Telehealth does not include:
  - An audio-only conversation;
  - An e-mail; or
  - A fax transmission.

HC-COV581 10-16
HC-COV668 12-17
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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

CIGNA HEALTH AND LIFE INSURANCE COMPANY
Home Office: Bloomfield, Connecticut
Mailing Address: 900 Cottage Grove Road
Hartford, Connecticut 06152

Important Information

Texas Department of Insurance Notice – Preferred Provider Plans

You have the right to an adequate network of preferred providers (also known as "network providers").

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
- If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

You have the right, in most cases, to obtain estimates in advance:

- from out-of-network providers of what they will charge for their services; and
- from your insurer of what they will pay for the services.

You may obtain a current directory of preferred providers at the following website: www.cigna.com or by calling 1-888-992-4462 for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

- If you are treated by a provider or Hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

  If the amount you owe to an out-of-network Hospital-based radiologist, anesthesiologist, pathologist, emergency department Physician, or neonatologist is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network Hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.

HC-IMP152 01-15

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Cigna's toll-free telephone number for information or to make a complaint at:

1-800-244-6224

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 490-1007

Web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Cigna para obtener información o para presentar una queja al:

1-800-244-6224

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre companías, coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 490-1007

Web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR DE SEGUROS O RECLAMAIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamacion, usted debe comunicarse con la companía primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU POLIZA: Este aviso es solamente para propositos informativos y no se convierte en parte o en condición del documento adjunto.

HC-IMP211 03-17
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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

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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 annual mammogram for women 35 years of age and older for an annual screening by low dose mammography for the presence of occult 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. Unless you are enrolled in a Health Savings Account or a High Deductible Health Plan, a Deductible will not apply.
- 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 for screening medical procedures for up to $200 for one of the following non-invasive screening tests for atherosclerosis and abnormal artery structure and function every five years for covered individuals who meet certain criteria:
  - computed tomography (CT) scanning measuring artery calcification; or
  - ultrasonography measuring carotid intima-media thickness and plaque.

  To qualify for coverage covered individuals must be:
  - a male older than 45 years of age and younger than 76 years of age or a female older than 55 years of age and younger than 76 years of age

    AND
  - diabetic or have high risk of developing coronary heart disease based on a score derived using the Framinghan Heart Study prediction algorithm that is intermediate or higher.
- The screening must be performed by a laboratory that is certified by a national organization recognized by the Commissioner of Insurance (by rule).
- 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; or
  - 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 for diagnosis, consultation, treatment, transfer of medical data, and medical education.

  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.

  The term Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of

medical data, and medical education through the use of interactive audio, video, or other electronic media. It does not include the use of telephone or fax.

- 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 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).

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.

Clinical Trials

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-COV675 01-18

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Enteral Nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Coverage includes Medically Necessary amino acid-based elemental formulas and the services associated with administration of the formulas when prescribed by the treating Physician, regardless of the formula delivery method, that are used for the diagnosis and treatment of: immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins; severe food protein-induced enterocolitis syndrome; eosinophilic disorders, as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by

disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract, phenylketonuria (PKU) or a heritable disease.

For other diagnosis not specified above, coverage for enteral nutrition and supplies required for enteral feedings is provided when all of the following conditions are met:

- It is necessary to sustain life or health.
- It is used in the treatment of, or in association with, a demonstrable disease, condition or disorder.
- It requires ongoing evaluation and management by a Physician.
- It is the sole source of nutrition or a significant percentage of daily caloric intake.

Coverage for enteral nutrition does not include:

- Regular grocery products that meet the nutritional needs of the patient (e.g. over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or
- Medical food products that:
  - are prescribed without a diagnosis requiring such foods;
  - are used for convenience purposes;
  - have no proven therapeutic benefit without an underlying disease, condition or disorder;
  - are used as a substitute for acceptable standard dietary intervention; or
  - are used exclusively for nutritional supplementation.

HC-COV675 01-18
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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-PHR213 10-16
ET

Limitations

Supply Limits

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-PHR267 01-18
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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
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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.

HC-TRM27 04-10
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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.

HC-DFS913 11-16
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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

NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

PEOPLE ENTITLED TO COVERAGE

You must be a Utah resident.

You must have insurance coverage under an individual or group policy.

POLICIES COVERED

ULHIGA provides coverage for certain life, health and annuity insurance policies.

EXCLUSIONS AND LIMITATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.

- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's guaranty association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.
- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefits plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of ULHIGA, including health plans, fraternal benefits societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or $500,000 - whichever is lower. Other caps also apply:

$200,000 in net cash surrender values.

$500,000 in life insurance death benefits (including cash surrender values).

$500,000 in health insurance benefits.

$200,000 in annuity benefits - if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.

$5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).

Interest rates on some policies may be adjusted downward.

DISCLAIMER

PLEASE READ CAREFULLY:

COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.

COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.

THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMER CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL MANAGED AND FINANCIALLY STABLE. INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.

THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW:

Utah Life and Health Insurance Guaranty Association, 955 E. Pioneer Rd., Draper, Utah 84020.

Utah Insurance Department, State Office Building, Room 3110, Salt Lake City, Utah 84114.

HC-IMP13 04-10

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Covered Expenses

- coverage for at least 48 hours of inpatient care following a normal vaginal delivery and at least 96 hours of inpatient care following a cesarean section. Charges for the newborn will also be covered.

Autism Spectrum Disorder

This benefit plan covers charges for the diagnosis and treatment of autism spectrum disorder for a Dependent child. Treatment for autism spectrum disorder means evidence-based care and related equipment prescribed for a child diagnosed with an autism spectrum disorder including pharmacy care; psychiatric care; psychological care; therapeutic care; an individual assessment once every 6 months, and at least 600 hours per year of behavioral health treatment.

Health care providers are required to submit a treatment plan to Cigna within 14 days of starting treatment for a member. Cigna may require a review of the treatment plan, but not more than once in a 6 month period.

Behavioral health treatment means counseling and treatment programs, including applied behavioral analysis (ABA therapy).

Therapeutic care means services provided by licensed or certified speech therapists, occupational therapists, or physical therapists.

Pharmacy care means medications prescribed by a licensed Physician and any health-related services considered Medically Necessary to determine the need or effectiveness of the medications.

Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological care means direct or consultative services provided by a Psychologist licensed in the state in which the Psychologist practices.

HC-COV704 12-17

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Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- 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 with no break in coverage of more than 63 days.

    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. During the next two years the plan may, from time to time, require proof of the continuation of such condition and dependence. After that, Cigna may require proof no more than once a year.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

A child also includes a legally adopted child, including that child from the date of placement for adoption. Coverage for an adopted child will begin from:

- the moment of birth, if adoption occurs within 30 days of the child's birth; or
- the date of placement, if placement for adoption occurs 30 days or more after the child's birth.

This coverage requirement ends if the child is removed from placement prior to the child being legally adopted.

"Placement For Adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

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.

When an administrative or court order exists, coverage will be provided by Cigna without regard to the enrollment period, dependency, residence or service area. You, your lawful spouse, or your Domestic Partner, state agency, or child support enforcement program may enroll the child.

A child may not be denied coverage on the sole basis that the child does not reside with you or because the child is solely dependent on a former spouse or Domestic Partner rather than you.

HC-DFS984 10-16

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

CERTIFICATE RIDER – Washington Residents

Rider Eligibility: Each Employee who is located in Washington

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

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

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

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Notice

Coordination of Benefits Included – See Table of Contents for Location of Coordination of Benefits Section. Your Benefits may be affected by other Insurance.

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Customer Service

HIPAA Privacy Statement

Your privacy is important to us. The following website explains how we collect and protect information about you:

www.cigna.com/privacyinformation

You may also request copies of this information by contacting customer service at the number shown on your ID card

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract or your rights under the law, you may contact the Office of Insurance Commissioner at 800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Health Department at 800-525-0127.

Notice Regarding Coordination of Benefits

If you are covered by more than one health benefit plan and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.

CAUTION: All health plans have timely claims filing requirements. If you or your provider fails to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delay in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

American Indian Health Services

American Indians, who are covered by this plan, may use the services of the Indian Health System under the same terms and conditions as an insured who uses in-network benefits and services.

Pharmacy Disclosures

Your Prescription Drugs Rights

You have the right to safe and effective pharmacy services. You also have the right to know what drugs are covered by your plan and the limits that apply. If you have a question or concern about your prescription drug benefits, please contact Cigna at the phone number on the back of your ID card or visit www.cigna.com/product-disclosures, under Washington or visit www.mycigna.com. If you would like to know more about your rights or if you have concerns about your plan, you may contact the Washington state office of insurance commissioner at 1-800-562-6900 or www.insurance.wa.gov. If you have a concern about the pharmacists or pharmacies serving you, please contact the Washington state department of health at 360-236-4700, www.doh.wa.gov, or HSQACSC@doh.wa.gov.

1. The Prescription Drug coverage provided by this plan uses the following provisions in the administration of coverage:
   - Exclusion of certain Prescription Drug Products from the Prescription Drug List;
   - Therapeutic drug substitution;
   - Incentives for use of generic drugs; such as step-therapy requirements and cost share incentives;
   - Prior authorization requirements;
   - Prescription Drug List changes;
   - Supply limit requirements; and
   - Specialty Prescription Drug Product requirements.

   These provisions are explained in the **Prescription Drug Benefit** section of this certificate.
2. The **Prior Authorization Requirements** section of this certificate explains the process that you and your Physician must use to seek coverage of a Prescription Drug Product that is not on the Prescription Drug List or is not the preferred Prescription Drug Product for a covered medical condition.
3. You may be eligible to receive an emergency fill for a Prescription Drug Product at a non-Network Pharmacy if Cigna determines that the Prescription Order could not reasonably be filled at a Network Pharmacy. Your payment will be based on the Usual and Customary Charge

submitted by the non-Network Pharmacy. You also may be eligible to receive an emergency fill for a Prescription Drug Product while a prior authorization request is being processed. The process for requesting this emergency fill and the cost share requirements for this emergency fill are described in the **Prescription Drug Benefit, Medication Synchronization and Emergency Fills Medication** section of this certificate.

4. The **Prescription Drug List Management and New Prescription Drug Products** sections in the **Prescription Drug Benefits** section of this certificate explain the process for developing coverage standards and the Prescription Drug Lists.
5. The **Prescription Drug List Management and New Prescription Drug Products** sections in **the Prescription Drug Benefits** section of this certificate explain the process for changing coverage standards and the Prescription Drug Lists. Additionally, the **Prior Authorization Requirements** section of this certificate explains the process that you and your Physician must use to seek coverage of a Prescription Drug Product that is not on the Prescription Drug List or is not the preferred Prescription Drug Product for a covered medical condition. The length of the authorization will depend on the diagnosis and Prescription Drug Product. There are instances when an approved Prescription Drug Product coverage exception may be grandfathered to allow ongoing coverage.
6. Coverage status of a Prescription Drug Product may change periodically. As a result of coverage changes the plan may require you to pay more or less for that Prescription Drug Product or try another covered Prescription Drug Product(s).
7. The Prescription Drug Product dispensing fee is considered to be a pharmacy-related service which is reimbursed by the plan.
8. The **Exclusion** section in the **Prescription Drug Benefits section of this certificate** lists the categories of excluded Prescription Drugs.

Items to be Available on Request

You may obtain copies of the following documents at www.cigna.com/product-disclosures, under Washington.

You may also request copies of the following documents by contacting customer service at the phone number listed on the back of your ID card, or by logging on to www.mycigna.com.

- any documents, instruments, or other information referred to in the Policy or certificate;
- Pharmacy question and answer document;
- a full description of the procedures to be followed by an insured for consulting a provider other than the primary care provider and whether the insured's primary care provider, or Cigna's medical director, or another entity must authorize the referral;
- procedures, if any, that an insured must first follow for obtaining prior authorization for health care services;
- a written description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between Cigna and a provider or network;
- descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to Specialists;
- an annual accounting of all payments made by Cigna which have been counted against any payment limitations, visit limitations, or other overall limitations on a insureds coverage under the plan;
- a copy of Cigna's grievance process for claim or service denial and for dissatisfaction with care; and
- accreditation status with one or more national managed care accreditation organizations, and whether Cigna tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data.
- access to and copies of all information relevant to a claim.
- the criteria, processes, strategies, evidentiary standards and other factors used to make medical necessity determinations of MH/SUD benefits and apply an NQTL to medical/surgical and MH/SUD benefits under the plan.
- A copy of the current Prescription Drug List.
- A list of participating primary care and specialty care providers.

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Eligibility - Effective Date

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance will be automatically insured for Medical Insurance for the first 31 days of life. If payment of an additional premium is required to provide coverage for a child, to continue coverage beyond 31days, you must elect Dependent Medical Insurance for your newborn child within the 60 day enrollment period which begins on the first day of birth. If Dependent Medical Insurance is not elected within the 60 day enrollment period, you may be required to wait until the next

plan enrollment period to enroll the child for coverage under the plan. Coverage shall include, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth.

HC-ELG222 ET

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

For children, you may designate a pediatrician as the Primary Care Physician.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which you requested the change.

HC-IMP1

V10-ET

Certification Requirements

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Continuity of Care

- There may be instances in which your participating provider becomes unaffiliated with Cigna's network. In such cases you will be notified and provided assistance with selecting a new provider.
- However, under special medical circumstances, you may be able to continue seeing your provider, even though he or she is no longer affiliated with Cigna. This allows continued, uninterrupted care until safe transfer to a participating provider can be arranged. If you are undergoing an active course of treatment for an acute or chronic condition and continued treatment is Medically Necessary, you may be eligible to receive continuing care from the non-participating provider for at least 60 days or until the end of the next open enrollment period, subject to the treating provider's agreement. You may also be eligible to receive continuing care if you are in your second or third trimester of pregnancy. In this case, continued care may be extended through your delivery and include a period of postpartum care.
- You may request continuity of care from Cigna after your participating provider's termination. Continuity of care must be Medically Necessary and approved in advance by Cigna. Your provider must agree to accept our reimbursement rate and to abide by Cigna's policies and procedures and quality assurance requirements. Continuity of care will cease if your treatment is successfully transitioned to a participating provider.
- There may be circumstances when continued care by a provider no longer participating in Cigna's network will not be available, such as when the provider loses his or her license, is terminated for cause, or retires.

HC-PAC68 ET1

Covered Expenses

- charges made in connection with mammograms for breast cancer screening if prescribed by a Physician, an advanced registered nurse practitioner or a physician assistant.
- charges made for an annual prostate-specific antigen test (PSA) and digital rectal exam.
- charges for colorectal cancer exams and laboratory tests consistent with the guidelines or recommendations of the United States preventative services task force of the federal centers for disease control and prevention: at the frequency identified in the recommendations and guidelines, as deemed appropriate by the patients Physician advanced registered nurse practitioner, or physician assistant after consultation with the patient; and to a covered individual who is:
  - at least 50 years old; or
  - less than 50 years old, but considered high risk according to the guidelines and recommendations.
- charges made for a drug that has been prescribed to treat a life-threatening illness for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be covered, provided: (a) it is recognized for the specific type of illness for which the drug has been prescribed in any one of the following established reference compendia: United States Pharmacopeia Drug Information; American Medical Association Drug Evaluation; American Hospital Formulary Service; other compendia identified by state or federal government; the majority of related peer-reviewed medical literature; or the Federal Secretary of Health and Human Services; (b) the drug has been otherwise approved by the FDA; and (c) the drug has not been contraindicated by the FDA for the use prescribed.

- charges incurred by a Dependent child for Medically Necessary neurodevelopmental therapies, including, speech, occupational or physical therapies when rendered by a licensed Physician. Benefits include services to restore and improve function, as well as, maintenance to prevent deterioration in the patient's condition, unless otherwise covered by the plan.
- charges made for general anesthesia services and related facility charges in conjunction with any dental procedure performed in a Hospital or Free-Standing Surgical Facility if such anesthesia services and related facility charges are Medically Necessary because the covered person:
  - is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
  - has a medical condition that the person's Physician determines would place the person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the person's Physician.
- charges made for women's health care services. Women's health care services include, but are not limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services.

  Coverage is provided for health care services for maternity patients and newly born children ordered by the Attending Provider. Decisions regarding the appropriate length of an inpatient stay, post delivery care and follow-up care for a mother and her newly born child will be made by the Attending Provider, in consultation with the mother. These decisions must be based on accepted medical practice and medical necessity as determined by the Attending Provider. Follow up care includes but is not limited to, the services of the Attending Provider, home health agencies and licensed registered nurses.

  The term "Attending Provider" means a provider who is working within the scope of his or her license and has clinical hospital privileges. Attending Providers include, but are not limited to: a licensed Physician; a licensed certified nurse midwife; a licensed midwife, a licensed physician's assistant; or a licensed advanced registered nurse practitioner.
- charges made for orally administered anti-cancer medication prescribed to kill or slow cancer cell growth are paid at the same cost share as intravenous or injectable anti-cancer drugs.
- charges for the treatment for insulin using diabetes, non-insulin using diabetes, or elevated blood glucose levels induced by pregnancy, including:
  - diabetes equipment including blood glucose monitors, insulin pumps and accessories, insulin infusion devices, foot care appliances for prevention of complications associated with diabetes;
  - diabetes outpatient self-management training and education;
- charges made for ABA therapy.
- charges made for acupuncture/acupressure.
- charges made for gender transition process including gender reassignment surgery (male-to-female or female-to-male) including, when applicable, hormone therapy, counseling services, orchiectomy, vaginoplasty (including colovaginoplasty, penectomy, labiaplasty, clitoroplasty, vulvoplasty, penile skin inversion, repair of introitus, construction of vagina with graft, coloproctostomy), vaginectomy (including colpectomy, metoidioplasty with initial phalloplasty, urethroplasty, urethromeatoplasty), hysterectomy and salpingo-oophorectomy, breast augmentation and reconstruction, as well as initial mastectomy or breast reduction.
- charges made for a second opinion regarding any medical diagnosis or treatment plan from a qualified Participating Provider of the insured's choice.
- charges made for any health care service performed by a pharmacist if the service performed was within the lawful scope of such person's license, the plan would have provided benefits if the service had been performed by a Physician, an advanced registered nurse practitioner or a physician's assistant; and the pharmacist is included in the plan's network of Participating Providers.
- charges made for a health care service provided to a covered person through telemedicine store and forward technology if:
- the plan provides coverage of the health care service when provided in person by the provider;
- the health care service is Medically Necessary; and
- the health care service is a service recognized as an Essential Health Benefit.

  If the service is provided through store and forward technology there must be an associated office visit between the covered person and the referring health care provider. Telemedicine can be utilized for the associated office visit.

  Telemedicine means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of

diagnosis, consultation, or treatment. Telemedicine does not include the use of audio-only telephone, facsimile, or email.

Reimbursement of store and forward technology is available only for those covered services specified in the negotiated agreement between the health carrier and the health care provider.

An originating site for a telemedicine health care service includes a: Hospital; Rural health clinic; Federally qualified health center; Physician's or other health care provider's office; Community mental health center; Skilled nursing facility; or Renal dialysis center, except an independent renal dialysis center or your home or any location determined by the individual receiving the service.

Any originating site may charge a facility fee for infrastructure and preparation of the patient. Reimbursement must be subject to a negotiated agreement between the originating site and the health carrier.

A distant site or any other site not identified in the above bullets may not charge a facility fee.

Telemedicine or store and forward technology health service is subject to all terms and conditions of the plan including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable health care service provided in person.

A health carrier is not required to reimburse: an originating site for professional fees; a provider for a health care service that is not a covered benefit under the plan; or an originating site or health care provider when the site or provider is not a contracted provider under the plan.

Distant site means the site at which a Physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine.

Originating site means the physical location of a patient receiving health care services through telemedicine.

Store and forward technology means use of an asynchronous transmission of a covered person's medical information from an originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered person, and does not include the use of audio-only telephone, facsimile, or email.

Covered Expenses - Mental Health and Substance Use Disorder

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

Clinical Trials

This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

(b) either:
   - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
   - the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials including an IRB of an institution in the state that has an agreement with the Office for Human Research Protections at DHHS;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

- the investigational drug, item, device, or service, itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If your plan includes In-Network providers, clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual's state of residence.

Coverage includes medically approved formulas prescribed by a Physician for treatment of phenylketonuria (PKU) and Medically Necessary elemental formula, regardless of delivery method, when a licensed provider with prescriptive authority diagnoses a patient with an eosinophilic gastrointestinal associated disorder and orders and supervises the use of the elemental formula. Coverage for enteral nutrition and supplies required for enteral feedings is provided when all of the following conditions are met:

- It is necessary to sustain life or health.
- It is used in the treatment of, or in association with, a demonstrable disease, condition or disorder.
- It requires ongoing evaluation and management by a Physician.
- It is the sole source of nutrition or a significant percentage of daily caloric intake.

Coverage for enteral nutrition does not include:

- Regular grocery products that meet the nutritional needs of the patient (e.g. over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or
- Medical food products that:
  - are prescribed without a diagnosis requiring such foods;
  - are used for convenience purposes;
  - have no proven therapeutic benefit without an underlying disease, condition or disorder;
  - are used as a substitute for acceptable standard dietary intervention; or
  - are used exclusively for nutritional supplementation.

HC-COV729 ET

Home Health Services

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals.

A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day.

Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations in The Schedule. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

HC-COV5 V5-ET1

Mental Health and Substance Use Disorder Services

Mental Health Services are inpatient, outpatient facility, partial hospitalization or outpatient services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes as listed in the current version of the Diagnostic and Statistical Manual (DSM). In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Use Disorder.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent are Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

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

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital, and is provided in an individual, group Mental Health Partial Hospitalization or Mental Health Intensive Outpatient Therapy Program, and in the home setting for Applied Behavior Analysis when based on accepted medical practice and Medical Necessity as determined by your Provider.

Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program in accordance with the laws of the appropriate, legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Use Disorder Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent are Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Partial Hospitalization sessions and Residential Treatment services.

Substance Use Disorder Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Use Disorder conditions.

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorder Rehabilitation Services

Services provided for the diagnosis and treatment of Substance Use Disorder or addiction to alcohol and/or drugs, while you or your Dependent are not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program.

Substance Use Disorder Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Use Disorder Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders, unless otherwise covered by the plan.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

HC-COV736 ET

Prescription Drug Benefits

Limitations

Prescription Topical Ophthalmic Products

A pharmacist may, without consulting a Physician or obtaining a new prescription or refill authorization from a Physician, provide for one early refill of a prescription for topical ophthalmic products if:

- the refill is requested by a patient at or after seventy percent of the predicted days of use of :
  - the date the original prescription was dispensed to the patient; or
  - the date that the last refill of the prescription was dispensed to the patient;
- the prescriber indicates on the original prescription that a specific number of refills will be needed; and
- the refill does not exceed the number of refills that the prescriber indicated.

Medication Synchronization and Emergency Fills Medication

Medication synchronization refers to the coordination of medication refills for a patient taking two or more medications for a chronic condition such that the patient's medications are refilled on the same schedule for a given time period.

If you or your Dependent requests medication synchronization for a new prescription, your prescription may be filled as follows:

- for less than a one-month supply of the Prescription Drug or Related Supply if synchronization will require more than a fifteen-day supply of the Prescription Drug or Related Supply; or
- for more than a one-month supply of the Prescription Drug or Related Supply if synchronization will require a fifteen-day supply of the Prescription Drug or Related Supply or less.

Upon your request, the prescribing provider or pharmacist shall:

- Determine that filling or refilling the prescription is in your best interest, taking into account the appropriateness of synchronization for the drug being dispensed;
- Inform you that the prescription will be filled to less than the standard refill amount for the purpose of synchronizing your medications; and
- Deny synchronization on the grounds of threat to patient safety or suspected fraud or abuse.

Emergency fill refers to a limited dispensed amount of medication that allows time for the processing of a prior authorization request. If you or your Dependent request an emergency fill, the authorized amount of the emergency fill will be no more than the prescribed amount up to a seven day supply or the minimum packaging size available at the time the emergency fill is dispensed.

Emergency fill only applies to those circumstances where a patient presents at a Participating Pharmacy with an immediate therapeutic need for a prescribed medication that requires a prior authorization. An emergency fill does not necessarily constitute a covered health service under this plan. Determination as to whether the emergency fill is a covered health service under this plan will be made as part of the prior authorization process.

The cost sharing for a Prescription Drug or Related Supply subject to coinsurance that is dispensed for less than the standard refill amount for the purpose Medication Synchronization or emergency fills will be adjusted. The cost sharing for Prescription Drug or Related Supply with a copayment that is dispensed for less than the standard refill amount for the purpose of purpose Medication Synchronization or emergency fills will be adjusted by:

- Dividing the insured's copayment for the drug by the normal day supply for the medication to find the Daily Member Cost.
- Multiply the Daily Insured Cost of the drug by the day supply being used. This is the amount Cigna will use to apply for the copayment.

Prior Authorization Requirements

If the request is approved, your Physician will receive confirmation within forty-eight hours for an urgent care review, and within 5 calendar days for a non-urgent care review. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drug Products. The length of the authorization will depend on the diagnosis and Prescription Drug Products. 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 Products has been approved, you can contact the Pharmacy to fill the covered Prescription Order or Refill.

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drug Products is not authorized within forty-eight hours for an urgent care review and within 5 calendar days for a non-urgent care review.

If the information provided is not sufficient to approve or deny the claim, Cigna will, within twenty-four hours for an urgent care review request, and within 5 business days for a non-urgent care review request, request that the Physician submit additional information to make the prior authorization determination. Cigna will give the Physician forty-eight hours for an urgent care review request or 5 calendar days for a non-urgent care review request to submit the requested information. Cigna will then approve or deny the request within forty- eight hours for an urgent care review or 4 calendar days for a non-urgent care review of the receipt of the requested additional information.

Whenever there is an adverse determination resulting in a denial, Cigna will notify the requesting Physician by one or more of the following methods: phone, fax and/or secure electronic notification, and also notify you or your Dependent in writing or via secure electronic notification. Status information will be communicated to the billing Pharmacy, via electronic transaction, upon Cigna's receipt of a claim after the request has been denied. Cigna will transmit these notifications within the time frames specified above based on if the review was urgent or non-urgent and in compliance with United States Department of Labor standards. If the request was made by the Pharmacy, notification will also be made to the prescriber.

A non-urgent care review request refers to any request for approval of care or treatment where the request is made in advance of the patient obtaining medical care or services, or a renewal of a previously approved request, and is not an urgent care request.

An urgent care review request refers to any request for approval of care or treatment where the passage of time could seriously jeopardize the life or health of the patient, seriously jeopardize the patient's ability to regain maximum function or, in the opinion of a provider with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the Prescription Drug Products should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

When Cigna establishes new limitations on coverage of a Prescription Drug Product, Cigna will ensure that prior notice of the change will be provided as soon as is reasonably possible to insureds who filled a prescription for the drug within the prior three months.

If an insured agrees to receive electronic notice and such agreement has not been withdrawn, Cigna will provide either electronic mail notice or written notice by first class mail at the last known address of the insured.

If these notice methods are not available because Cigna does not have contact information for the insured, Cigna will post notice on its web site or at another location that may be appropriate.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P & T Committee clinically evaluates the Prescription Drug for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the

case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Drug Substitution

FDA approved Prescribed Drug Products that are the sole prescription drug available for a covered medical condition will be covered. Coverage for a non-Prescription Drug List Prescription Drug Product will not be excluded if the only Prescription Drug List drug available for your covered condition is one that you cannot tolerate or that is not clinically efficacious for you.

Supply Limits

You may obtain a twelve-month refill of covered contraceptive drugs if prescribed by your provider or you may request a smaller supply. If available, you may receive the contraceptives on site at the doctor's office. During the last quarter of the plan year the refill amount may be limited if a twelve-month supply of the contraceptive drug has already been dispensed during the plan year.

HC-PHR276 ET

Payment of Benefits

Medical

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person or facility to whom it was made; or offset the amount of that overpayment from a future claim payment.

Except in the case of fraud, when an overpayment has been made by Cigna to a healthcare provider, Cigna will not have the right to:

(a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless the request is made in writing to the provider within twenty-four months after the date that the payment was made; or

(b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why Cigna believes the provider owes the refund. If a provider fails to contest the request in writing to Cigna within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

Cigna will not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim:

(a) Request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within thirty months after the date that the payment was made; or

(b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why Cigna believes the provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If a provider fails to contest the request in writing to Cigna within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

Cigna may at any time request a refund from a health care provider of a payment previously made to satisfy a claim if:

(a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and

(b) Cigna is unable to recover directly from the third party because the third party has either already paid or will pay the provider for the health services covered by the claim.

HC-POB156 ET

Termination of Insurance

Continuation of Insurance During Strike, Lockout or Other Labor Dispute

If your Medical Insurance will end due to a strike, lockout, or other labor dispute, under Washington law, you may elect to continue medical benefits for yourself and your insured Dependents. Your Employer will notify you of your right to continue your medical coverage. This notice will specify the amount of your premium payment, when your premium payments are due and the address to mail your payment. You must complete the application included with the notice and return it to your Employer with the required premium.

Medical benefits for your continued coverage will be those in effect on the day before the labor dispute began.

Your medical coverage will be continued until the earlier of:

- the last day for which you have made any required contribution for the insurance;
- the date the group policy terminates;
- the end of a period 6 months from the date your continued coverage began.

You must notify your Employer in writing if you become eligible for other group medical coverage prior to the end of the continuation period.

HC-TRM109 ET

Definitions

Concurrent Care Coverage Determination

Concurrent Care Coverage Determination means a medical necessity determination that is made during the period when the health care services or supplies are being provided to a customer including a) during on-going inpatient, intensive outpatient or residential behavioral healthcare treatment, b) during ongoing ambulatory care.

HC-DFS871 ET

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old.
- 26 or more years old, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability.

  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. The plan may require proof not more frequently than annually after the two year period following the child's attainment of the limiting age.

The term child means a child born to you or a child legally adopted by you including a child for whom you assume legal obligation for total or partial support, in anticipation of adoption, but with no requirement that the adoption be final. It also includes a stepchild. If your Domestic Partner has a child, that child will also be included as a Dependent.

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-DFS1040 ET

Domestic Partner

A Domestic Partner is defined as a person who has a valid domestic partner registration in Washington.

HC-DFS47 V8-ET

Prescription Drug Product

- The following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Glucagen, Glucogen emergency kits, insulin, injection aids, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips;
- Needles and syringes for self-administered medications or Biologics covered under the plan's Prescription Drug benefit; and
- Inhaler assistance devices and accessories, peak flow meters.

HC-DFS1019 ET

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets, injection aids, test strips for glucose monitors, visual blood sugar reading and urine testing strips, prescriptive oral agents for controlling blood sugar levels, glucogen emergency kits), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

HC-DFS68 V7-ET

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

CERTIFICATE RIDER – Wisconsin Residents

Rider Eligibility: Each Employee who is located in Wisconsin

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

GM6000 HC-ETWIRDR

Termination of Insurance

Special Continuation of Medical Insurance

If your insurance ceases for any reason other than discontinuance of the policy; failure to make any required contributions; or termination of employment due to misconduct; and if you have been insured for at least three consecutive months, you may continue your Medical Insurance by paying the required premiums to the Employer. In no event will the insurance be continued beyond the earliest of the following dates:

- 18 months from the date the insurance would otherwise cease;
- the last day for which you have paid the required premium;
- the date you become eligible for similar group coverage;
- the date the group policy cancels.

If your insurance is being continued as described above, the Medical Insurance for any one of your Dependents insured on the date your insurance would otherwise cease may be continued under the same conditions shown above, until the date your insurance ceases or, with respect to any one Dependent, the date that Dependent ceases to qualify as a Dependent, whichever comes first.

For Dependents of Deceased Employee

If you die while insured, your Dependents who are insured at the time of your death may continue their Medical Insurance by paying the required premium to the Employer, but in no event beyond the earliest of the following dates:

- 18 months from the date of your death;
- the last day for which the required premium has been paid;
- with respect to any one Dependent, the date that Dependent becomes eligible for similar group coverage; or the date that Dependent ceases to qualify as a Dependent for any reason other than lack of primary support by you;
- the date the policy cancels.

For Spouse Upon Divorce From Employee

If your spouse's Medical Insurance would otherwise terminate because of divorce or annulment of marriage, your former spouse may continue the insurance by paying the required contribution to the Employer, but in no event beyond the earliest of the following dates:

- 18 months from the date the insurance would otherwise cease;
- the last day for which the required contribution has been paid;
- the date that your former spouse becomes eligible for similar group coverage;
- the date you are no longer insured under the policy;
- the date this policy cancels.

If the insurance on your former spouse is being continued under a group policy that was replaced by this policy, such spouse will be eligible for continuance under this policy, subject to the other provisions of this policy. However, the insurance will not be continued beyond a period of time totaling more than 18 months under both policies combined.

Notification of Special Continuation

The Employer will notify in writing any eligible person, within five days after the date that person's insurance would otherwise cease, of his right to elect the continuation. The eligible person may elect the continuation by applying in writing and sending the required contribution to the Employer within 30 days after the day he receives written notice of his option to continue his insurance.

Conversion Available Following Continuation

The terms of the "Medical Conversion Privilege" section will apply following the termination of insurance.

The terms of this section will not reduce any continuation of insurance otherwise provided.

HC-TRM59 04-10
V1-ET

Definitions

Grievance

The term Grievance means any written dissatisfaction by you or your Dependent with Cigna's administration, claims practices or provision of services.

HC-DFS221 04-10
V1-ET

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

CERTIFICATE RIDER – Wyoming Residents

Rider Eligibility: Each Employee who is located in Wyoming

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

HC-ETWYRDR

Covered Expenses

- charges for cancer screening tests, including: a pelvic examination, pap smear and clinical breast cancer examination, including a mammogram; a prostate examination and laboratory tests; and a colorectal cancer examination and laboratory tests for any non-symptomatic person.

HC-COV651 01-18
ET

Definitions

Medical Necessity

Medical Necessity means:

- A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:
  - Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury;
  - Provides for the diagnosis, direct care and treatment of the patient's condition, illness, disease or injury;
  - Is in accordance with professional, evidence based medicine and recognized standards of good medical practice and care; and
  - Is not primarily for the convenience of the patient, physician or other health care provider.
- A medical service, procedure or supply shall not be excluded from being a Medical Necessity under this section solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by:
  - Peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or
  - Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act.

HC-DFS953 10-16
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