

University of New England

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2017

ETALLM17A
3332272

This document printed in December, 2016 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: University of New England
Rider Eligibility: Each Employee as noted within this certificate rider
Policy No. or Nos.: 3332272
Effective Date: January 1, 2017

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 Maine:

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

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

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

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

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


Anna Krishtul, Corporate Secretary

HC-ETDRD



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

CERTIFICATE RIDER – Arizona Residents

Rider Eligibility: Each Employee who is located in Arizona

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

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

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

HC-ETAZRDR

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

VI-ET

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).

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.

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-ELG11

07-14

V3-ET1

Covered Expenses

- charges made for medical foods to treat inherited metabolic disorders. Metabolic disorders triggering medical food coverage are: part of the newborn screening program as prescribed by Arizona statute; involve amino acid, carbohydrate or fat metabolism; have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and require specifically processed or treated medical foods that are generally available only under the supervision and direction

of a Physician, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

For the purpose of this section, the following definitions apply:

- “Inherited Metabolic Disorder” means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program as prescribed by Arizona statute.
- “Medical Foods” means modified low protein foods and metabolic formula.
- “Metabolic Formula” means foods that are all of the following: formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy; processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and essential to a person’s optimal growth, health and metabolic homeostasis.
- “Modified Low Protein Foods” means foods that are all of the following: formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy; processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and essential to a person’s optimal growth, health and metabolic homeostasis.

HC-COV95

05-15
V5-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
VI-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 Micromedex 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-COV441
HC-COV443

05-15
V1-ET1

Definitions

Dependent

Dependents include:

- your lawful spouse; or
- your Domestic Partner.

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

HC-DFS158

04-10
V1-ET2

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-DFS159

04-10
V1-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-ETCRDR

Covered Expenses

- charges for licensed ambulance service to or from a Hospital.

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-COV439

05-15
V1-ET

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-DFS673

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V5-ET3

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

CERTIFICATE RIDER – District of Columbia Residents

Rider Eligibility: Each Employee who is located in District of Columbia

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

HC-ETDCRDR

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

Certification Requirements

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

- as a registered bed patient, except for 48/96 hour maternity stays;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for Mental Health or Substance Abuse Residential Treatment Services.

HC-PAC11

11-14
V2-ET

Covered Expenses

- charges made for an annual prostate-specific antigen test (PSA).
- charges made for uniform, age-appropriate health screenings consistent with the standards and schedules of the American Academy of Pediatrics for a Dependent Child to age 21.
- charges made for diabetic services for insulin-using diabetes, noninsulin-using diabetes and gestational diabetes. Services and supplies including glucometers; blood glucose monitors for the legally blind; insulin pumps; infusion devices and related accessories, including those adaptable for the legally blind; podiatric appliances; and glucagon emergency kits.
- charges for the equipment, supplies and other outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes if prescribed by a qualified health care-professional authorized to prescribe such items.
- charges for insulin, syringes, prefilled insulin cartridges for the blind, oral blood sugar control agents, glucose test strips, visual reading ketone strips and urine test strips, and injection aids (i.e. lancets, alcohol swabs).
- charges for colorectal cancer screening, specifically, screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recent published recommendations established by the

American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.

HC-COV467

05-15
V1-ET

Mental Health and Substance Abuse 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 Abuse 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 Abuse.

Inpatient Mental Health Services are 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 Partial Hospitalization and Mental Health 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.

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 are 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 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.

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. 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 Abuse Rehabilitation Services are 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 Abuse Services include Partial Hospitalization sessions and 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 Abuse 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 Abuse conditions.

Substance Abuse Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; 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 Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services are 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 Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. 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 Abuse Detoxification Services for 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 Abuse Services:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- 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.

Definitions

Dependent

A child also includes a minor grandchild, niece or nephew for whom you provide food, clothing and shelter on a regular and continuous basis when the District of Columbia schools are in regular session, provided such child's legal guardian, if not you, is not covered by an accident or Sickness policy.

HC-DFS706

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Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

HC-DFS184

04-10
VI-ET

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

CERTIFICATE RIDER – Florida Residents

Rider Eligibility: Each Employee who is located in Florida

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

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

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

The provisions set forth in this rider comply with the legal requirements of Florida group insurance plans covering

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

HC-ETFLDR

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-ELG9

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VI-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 otoacoustic 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-COV25

04-10

VI-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

VI-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
VI-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;
- 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-TRM25

04-10
VI-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

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-DFS162

07-14
V2-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 – 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-COV431

01-15
V2-ET2

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 – Kentucky Residents

Rider Eligibility: Each Employee who is located in Kentucky

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

HC-ETKYRDR

The Schedule

For charges made for Medically Necessary treatment of Mental Health and Substance Abuse Services, including any related prescription drug charges, Covered Expenses will be payable the same as for other illnesses, including any deductibles, Lifetime or annual maximums, day or visit or dollar limits, episodes of care limits, copayments, coinsurance levels, accumulation to any out-of-pocket amount, any increase to 100% once the out-of-pocket amount has been reached, and any other cost-sharing arrangements. Any Mental

Health or Substance Abuse deductibles, maximums, limits, copayments, coinsurance levels, out-of-pocket provisions, and cost-sharing arrangements shown in The Schedule that are not the same as for other illnesses will not apply.

SCHEDKY

Covered Expenses

- charges for cochlear implants for persons age 2 and over with the diagnosis of profound sensorineural deafness or postlingual deafness in adults. Cochlear implants for children under age 2 will be covered when, upon review, they are determined to be Medically Necessary.
- charges for the diagnosis and treatment of Autism Spectrum Disorders:

treatment for Autism Spectrum Disorders includes medical care, habilitative or rehabilitative care, pharmacy if covered by the plan, psychiatric care, psychological care, therapeutic care, and applied behavior analysis prescribed or ordered by a licensed health professional.

coverage is not subject to visit limits. Coverage is not subject to copayments, deductibles, or coinsurance that is less favorable than those applied to other covered services.

Cigna may request utilization review of the treatment once every 12 months, unless Cigna and the covered person's licensed Physician, psychiatrist, or psychologist agree that a more frequent review is necessary.

Liaisons are available to facilitate communication between You and Cigna regarding Autism Spectrum Disorder coverage. The responsibilities of the liaison include:

- explaining to the member the benefits for the treatment of autism under the member's health benefit plan and the specific process to access those benefits;
- explaining to the member the process for prior authorization of treatment, including communicating specific documentation needed from the member or provider for the insurer to consider the request;
- monitoring the adjudication of a member's claims for the treatment of autism services;
- explaining to the member the proper coding to use when submitting claims for applied behavioral analysis therapy and any supporting documentation required to be attached to the claim;
- explaining to the member, upon request, how claims for the treatment of autism services were adjudicated, including the application of any deductibles, copayments, coinsurance, and benefit limitations; and

- explaining to the member, upon request, any appeal rights the member may have regarding coverage for the treatment of autism that has been denied or limited.
- charges for a telehealth consultation provided the treating Physician or other provider facilitating the use of telehealth ensures that: informed consent of the patient or another person with authority to make the health care treatment decision for the patient, is obtained before covered services are provided through telehealth; and that the confidentiality of the patient's medical information and quality of care protocols are maintained. Telehealth means the use of interactive, audio, video or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data and medical education.
- charges for the necessary care and treatment of medically diagnosed inherited metabolic diseases. Coverage must include amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases provided that the amino acid products are prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic diseases, and are administered under the direction of a Physician.
- charges for or in connection with hospitalization, ambulatory surgical facility charges and general anesthesia for dental procedures provided the person being treated is: under nine years of age; or has serious mental, physical or behavioral problems and the Dentist or admitting Physician certifies that hospitalization or anesthesia is required to safely perform the procedures effectively.
- charges for hearing aids and all related services for persons under 18 years of age when prescribed by licensed audiologists and dispensed by an audiologist or hearing instrument specialist. Related services are services necessary to assess, select and appropriately adjust or fit the hearing aid to ensure optimal performance. A hearing aid is any wearable, nondisposable instrument or device designed to aid or compensate for impaired hearing and any parts, attachments or accessories, including earmolds, but excluding batteries and cords.

HC-COV523

05-15
ET2

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- medical and Hospital care and costs for the infant child of a Dependent beyond the first 31 days of life, unless this infant child is otherwise eligible under this plan.

HC-EXC219

05-15
ET

Termination of Insurance

Special Continuation of Medical Insurance

For Employees and Dependents

If your Medical Insurance would cease and if you have been insured for at least three consecutive months under this policy or a policy it replaces, upon payment of the required premium by you to your Employer, your Medical Insurance will be continued until the earliest of:

- 18 months from the date Medical Insurance would otherwise cease;
- the last day for which you have paid the required premium;
- the date you become eligible for insurance under another group policy for medical benefits or under Medicare;
- for a Dependent, the date that Dependent no longer qualifies as a Dependent;
- the date the policy cancels.

Your Employer will notify you in writing of your right to elect such continuation by sending you an election of continuation of coverage form, samples of which have been provided by the Insurance Company.

Within 31 days after the date notice was sent to you, you may elect such continuation in writing by returning the election of continuation of coverage form and paying the required premium.

HC-GEN

05-15
ET



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

CERTIFICATE RIDER – Louisiana Residents

Rider Eligibility: Each Employee who is located in Louisiana

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

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

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

HC-ETLARDR

Covered Expenses

- charges for electronic imaging/telemedicine health care services, including, but not limited to, diagnostic testing and treatment. The Physician must be physically present with the patient and communicating with a Physician at the facility receiving the transmission. Payment shall not be less than 75% of the reasonable and customary payment received for an intermediate office visit. These electronic/telemedicine benefits are subject to utilization review requirements.
- charges for treatment of severe mental illness, on the same basis as other sickness covered under the plan. “Severe mental illness” includes any of the following:
 - schizophrenia or schizoaffective disorder;
 - bipolar disorder;
 - panic disorder;
 - obsessive-compulsive disorder;
 - major depressive disorder;
 - anorexia/bulimia;
 - intermittent explosive disorder;
 - post-traumatic stress disorder;

- psychosis NOS (not otherwise specified) when diagnosed in a child under age 17;
- Rett’s Disorder;
- Tourette’s Disorder.

Autism Spectrum Disorder

Charges for the diagnosis and treatment of Autism Spectrum Disorders, including applied behavioral analysis, in individuals less than 17 years of age. Such coverage shall include the following care prescribed, provided or ordered by a physician or a psychologist who is licensed in this state who shall supervise provision of such care:

- Medically Necessary assessments, evaluations, or tests to diagnose an Autism Spectrum Disorder;
- Habilitative or rehabilitative care;
- Pharmacy care;
- Psychiatric care;
- Psychological care;
- Therapeutic care.

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

Clinical Trials

Charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:

- the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
- the trial investigates a treatment for terminal cancer and: the person has failed standard therapies for the disease; cannot tolerate standard therapies for the disease; or no effective nonexperimental treatment for the disease exists;
- the person meets all inclusion criteria for the clinical trial and is not treated “off-protocol”;
- the trial is approved by the Institutional Review Board of the institution administering the treatment.

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed herein as Exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);

- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per year for both pre- and post-genetic testing.

HC-COV190

04-10
VI-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, on a basis no less favorable than the out of network medical cost share for injectable/IV chemotherapy.

SCHEDPHARM-ET

Termination of Insurance

Continuation

Medical Insurance for Surviving Spouse

For purposes of this section, the term Surviving Spouse means your legal spouse who at the time of your death is:

- 50 or more years old; and
- insured as your Dependent for Medical Insurance.

If you die while insured for Medical Insurance, your Surviving Spouse may continue to be insured for such benefits subject to the terms set forth below.

Your Employer will notify your Surviving Spouse of his right to elect continuation of his Medical Insurance. Your Surviving Spouse, within 90 days of the date the insurance would otherwise cease, may elect such continuation in writing and by paying the required premium to your Employer. If your Surviving Spouse elects this option, his insurance will be continued until he:

- becomes eligible for another group medical plan;
 - becomes eligible for Medicare;
 - remarries; or
 - discontinues premium payments to your Employer;
- whichever occurs first.

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

Continuation of Medical Insurance during Active Military Duty

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

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

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

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

- the date Dependent Insurance is canceled.

Reinstatement of Medical Insurance

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

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

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

HC-TRM81

04-10
V1-ET

Definitions

Dependent

The term child includes any grandchild of yours provided such child is under 26 years of age and is in your legal custody and resides with you or any grandchild of yours who is in your legal custody and resides with you, and is incapable of self-sustaining employment by reason of mental or physical handicap which existed prior to the child's 26th birthday.

HC-DFS427

04-10
V1-ET1

Creditable Coverage

The term Creditable Coverage means coverage of an individual under: a group health plan; Health insurance coverage; Medicare coverage; Medicaid; Medical insurance coverage under the General Military Law; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered for federal employees; a public health plan; or a health benefit plan provided to members of the Peace Corps. Such term does not include coverage consisting solely of excepted benefits.

HC-DFS422

04-10
V1-ET

Dependent

Dependents include:

- any child of yours who is
 - 26 years old, but less than 30, unmarried, enrolled in school as a full-time student, primarily supported by you, and not already insured under a plan with creditable coverage. Please note, however, your Employer is not required to contribute to the premium for your Dependent student's coverage.
 - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of intellectual or physical disability.

The term child means a child born to you or a legally adopted child from the start of the state's adoption bonding period.

HC-DFS735

05-14
V1-ET

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.



For immediately required post-evaluation or post stabilization services, Cigna will provide access to a designated representative 24 hours a day, 7 days a week, to facilitate review, or otherwise provide coverage with no financial penalty to you.

HC-DFS393

05-14
V4-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
V2-ET

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. Benefits payable will not exceed \$350 per year.
- 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 HLA 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.

HC-COV250

01-14
V3-ET

Covered Expenses

Mental Health and Substance Abuse 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 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).

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 abuse 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 Abuse Services:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- 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-COV291

01-14
VI-ET

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
VI-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, the following are specifically excluded infertility services:

- reversal of male and female voluntary sterilization, including when the infertility is caused by or related to voluntary sterilization;
- medical services rendered to a covered person's surrogate and any surrogate fees;
- donor charges and services; and

- any experimental, investigational or unproven infertility procedures or therapies, until the procedure becomes recognized as non-experimental.

HC-COV85

01-14
V2-ET

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

VI-ET

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-DFS644

01-14

VI-ET1

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

CERTIFICATE RIDER – Michigan Residents

Rider Eligibility: Each Employee who is located in Michigan

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

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

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

HC-ETMRDR

Important Notices

Managed Care Disclosure

If you are currently insured for benefits under this plan, you may request information from Cigna as follows by written request only:

- detailed provider information including those not accepting new patients, practice type or specialty, and limitation of accessibility.
- professional credentials of providers participating in the plan.

- the Michigan Office of Financial and Insurance Regulation telephone number to obtain information regarding complaints and disciplinary action.
- detailed drug formulary information.
- information regarding financial relationship between Cigna and any closed provider panel.
- a telephone number for additional information in regard to the above.

HC-IMP91

04-10
VI-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 any drug approved by the FDA on the basis that the drug has not been approved for the treatment of the particular condition for which the drug has been prescribed. A drug and supplies Medically Necessary to administer the drug must be covered provided the following conditions are met:
 - the drug is approved by the FDA;
 - the drug is prescribed by an allopathic or osteopathic Physician for the treatment of a life threatening condition or a chronic and seriously debilitating condition as long as the drug is Medically Necessary to treat that condition and the drug is on the plan formulary or accessible through formulary procedures; and
 - the drug has been recognized for the specific indication prescribed in any one of the following: the American Medical Association Drug Evaluations; the American Hospital Formulary Service Drug Information; the United States Pharmacopoeia Drug Information or any two articles from major peer-reviewed medical journals.

The following benefits will be covered for prevention and treatment of diabetes:

- charges for podiatric appliances for prevention of complications associated with diabetes, blood glucose monitors, including for the legally blind, injection aids,

insulin pumps and medical supplies required for the use of an insulin pump;

- charges for diabetes self-management training provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the Department of Health, but limited to the following:
 - visits certified as Medically Necessary when diabetes is diagnosed; and
 - visits which are certified to be Medically Necessary following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management.
- test strips for glucose monitors, visual reading and urine testing strips, insulin, cartridges for legally blind, syringes, lancets and spring-powered lancet devices, glucagon emergency kits and nonexperimental medication for controlling blood sugar; medication used in the treatment of the feet, ankles or nails associated with diabetes.

Autism

- charges made for professional services for the diagnosis and treatment of Autism Spectrum Disorders, including Behavioral Health Treatment, Applied Behavior Analysis (ABA), Psychiatric care, Psychological care; Therapeutic care; and Pharmacy benefits (if plan includes prescription drug coverage) that develop, maintain, or restore to the maximum extent practicable, the functioning of an individual with Autism.

Cigna, as a condition of coverage may:

- require a review of the treatment consistent with current protocols and may, at its own expense, require a review of the Treatment plan;
- request the results of the Autism Diagnostic Observation Schedule that has been used in the diagnosis of an Autism Spectrum Disorder;
- request that the Autism Diagnostic Observation Schedule be performed not more frequently than once every three years; and
- request that an annual development evaluation be conducted and the results of that annual development evaluation be submitted to Cigna.

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

Autism Diagnostic Observation Schedule means the protocol available through western psychological services for

diagnosing and assessing Autism Spectrum Disorders or any other standardized diagnostic measure for Autism Spectrum Disorders that is approved by the commissioner of insurance, if the commissioner of insurance determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

Autism Spectrum Disorders means Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder not otherwise specified, in accordance with the Diagnostic and Statistical Manual (DSM).

Behavioral Health Treatment means evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

- Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
- Are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

HC-COV375

01-15

VI-ET

Definitions

Emergency Services

Emergency services are medical, surgical, Hospital and related health care services, including ground, air, or other ambulance service. Coverage is for medically necessary services for the sudden onset of a medical condition with signs and symptoms so severe, that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to one's body or life, including a pregnancy. Regardless of the diagnosis, benefits will be paid at least to the point of stabilization. Prior authorization is not required.

HC-DFS447

11-10

VI-ET

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

Eligibility – Effective Date

Dependent Insurance

Effective Date of Dependent Insurance

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until Cigna agrees to insure that Dependent. However, failure to elect insurance for disabled Dependents will not cause you to be considered a Late Entrant for Dependent Insurance and you may elect to insure them at any time.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

HC-ELG140

10-15

ET

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 made for hearing aids, including but not limited to semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound. Coverage is limited to one hearing aid per ear every three years, up to age 18.
- 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-COV386

01-15

HC-COV387

VI-ET4

Termination of Insurance

Employees

Your insurance will cease on the last day of the month of 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.

Dependents

Your insurance for all of your Dependents will cease on the last day of the month of the earliest date below:

- 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.

HC-TRM1

01-15
V8 ET

Termination of Insurance and Special Continuation

Reinstatement of Insurance

If your coverage ceases because of active duty in: the armed forces of the United States, or the National Guard, the insurance for you and your Dependents will be reinstated after your deactivation, provided that:

- you apply for such reinstatement within 90 days after deactivation; and
- you are otherwise eligible.

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

HC-TRM70

09-14
V2-ET1

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.

HC-BEX36

04-10
V1-ET

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.

HC-ETMTRDR

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 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.

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, devices 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.

HC-COV146

04-10
V1-ET

Home Health Services

- charges made for Home Health Care Services, by a licensed home health agency when prescribed by the insured's attending Physician as part of a written plan of care.

Home Health Care Services are provided if the patient's Physician determines that the home is a medically appropriate and cost-effective setting. Home Health Services are those skilled health care services that can be provided during intermittent visits of 2 hours or less by Other Health Care Professionals. Necessary consumable medical supplies, home infusion therapy and Durable Medical Equipment 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 not subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under "Short-term Rehabilitative Therapy".

HC-COV5

04-10
V3

Breast Reconstruction and Breast Prostheses

- 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.

HC-COV14

04-10
V5-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.
- 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

05-14
V2-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-DFSS87

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 – New Hampshire Residents

Rider Eligibility: Each Employee who is located in New Hampshire

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

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

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

HC-ETNHRDR

New Hampshire Patient Bill of Rights

The following information is being provided to you pursuant to RSA 415:18-XIV. These statutes require any insurer issuing a group or individual policy to provide each new certificate holder or policy holder with the following information. When admitted to a Hospital or Sanitarium:

- You shall be treated with consideration, respect, and full recognition of your dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom you have contact.
- You shall be fully informed of your rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by you in writing. When you lack the capacity to make informed judgments the signing must be by the person legally responsible for you.
- You shall be fully informed in writing in language that you can understand, before or at the time of admission and as necessary during your stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.
- You shall be fully informed by a health care provider of your medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of your total care and medical treatment, to refuse treatment, and to be involved in experimental research upon your written consent only. For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.
- You shall be transferred or discharged after appropriate discharge planning only for medical reasons, for your welfare or that of other patients, if the facility ceases to operate, or for nonpayment for your stay, except as prohibited by Title XVIII or XIX of the Social Security Act. You will not be involuntarily discharged from a facility

- because you become eligible for Medicaid as a source of payment.
- You shall be encouraged and assisted throughout your stay to exercise the patient's rights as a patient and citizen. You may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.
 - You shall be permitted to manage your personal financial affairs. If you authorize the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with your rights under this subdivision and in conformance with state law and rules.
 - You shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.
 - You shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect you or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect you or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.
 - You shall be ensured confidential treatment of all information contained in your personal and clinical record, including that stored in an automatic data bank, and your written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be your property. You shall be entitled to a copy of such records upon request. The charge for the copying of your medical records shall not exceed \$15 for the first 30 pages or \$.50 per page, whichever is greater; provided that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.
 - You shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by you, such services may be included in a plan of care and treatment.
 - You shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. You may send and receive unopened personal mail. You have the right to have regular access to the unmonitored use of a telephone.
 - You shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.
 - You shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.
 - You shall be entitled to privacy for visits and, if married, to share a room with your spouse if you both are patients in the same facility and where you both consent, unless it is medically contraindicated and so documented by a physician. You have the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.
 - You shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, or source of payment, nor shall any such care be denied on account of your sexual orientation.
 - You shall be entitled to be treated by your physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.
 - You shall be entitled to have your parents, if a minor, or spouse, or next of kin, or a personal representative, if an adult, visit the facility, without restriction, if you are considered terminally ill by the physician responsible for your care.
 - You shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.
 - You shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.
 - Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

HC-IMP53

01-11

VI-ET

Covered Expenses

- charges for or in connection with mammograms for breast cancer screening or diagnostic purposes not to exceed: one baseline low-dose mammogram for women ages 35 to 39 years of age; a mammogram every one to two years for women 40 to 49 years of age, even if no symptoms are present; and one annual mammogram for women age 50 and over.
- charges for 48 hours inpatient stay following a vaginal delivery or 96 hours following a cesarean section. An earlier discharge may be determined by the mother and attending

Physician. An additional length of stay will be covered if deemed medically necessary.

If discharge is prior to the 48/96 hours, at least 2 postpartum visits will be provided if the service is by a licensed Physician with experience in perinatal care. Postpartum visits shall include a physical assessment of mother and infant. The assessment shall include but not be limited to: infant nutrition and feeding, infant behavior, family interactions, safety and injury prevention, infant and maternal health promotion, and community resources. Providers of postpartum visits shall be licensed health care providers experienced in perinatal care.

HC-COV127

04-10
VI-ET

Continuation of Coverage Under New Hampshire State Law

Continuation of Medical Insurance – Employee

If you or your Dependent's insurance would otherwise cease because of termination of employment, for reasons other than gross misconduct or carrier termination, your Medical insurance will be continued for up to 18 months upon payment of the required premium by you to your Employer. It will continue until the earliest of:

- 18 months from the date your work hours are reduced or your employment terminates;
- the last day of the period for which you have paid the required premium;
- the date you or your Dependent becomes entitled to Medicare;
- the date you or your Dependent becomes eligible for insurance under another group policy for medical benefits;
- the date the policy is canceled;
- the date a Dependent ceases to qualify as a Dependent.

Continuation of Medical Insurance — Disabled Individuals

If you are or your Dependent is disabled within 60 days of the date of termination of employment, you may continue health insurance for up to an additional 11 months beyond the 18 month period. To be eligible you or your Dependent must:

- be declared disabled under Title II or XVI by the Social Security Administration; and
- notify the plan administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the plan administrator with a copy of the determination.

Continuation of Medical Insurance – Former Spouse

A covered former spouse is entitled to continue coverage following a final decree of divorce or legal separation, until the earliest of the following:

- the date you are no longer insured under the group policy for any reason (including the date of your death);
- the three-year anniversary of the final decree of divorce or legal separation;
- the date your former spouse remarries;
- the date you remarry;
- the date the court decree no longer requires continued coverage.

If coverage for a former spouse ends under this continuation provision for any of the reasons described, he or she is eligible to obtain up to an additional 36 months of continuation under the provision **Continuation of Medical Insurance - Dependent**.

Continuation of Medical Insurance — Dependent

If Medical insurance for your Dependents would otherwise cease because of: (1) your death; (2) your entitlement to Medicare; (3) divorce or legal separation; or (4) with respect to a Dependent child, failure to continue to qualify as a Dependent, Medical insurance may be continued upon payment of the required premium to the Employer. It will continue until the earliest of:

For a Dependent Child:

- 36 months from the date of (1), (2), (3) or (4) above or when coverage reduction or termination takes place within one year of the date the Employer files for protection under the bankruptcy provisions of Title 11 of the United States Code, whichever may occur first;
- the last day for which the required premium has been paid;
- the date the Dependent child ceases to be a Dependent child;
- the date the Dependent becomes entitled to Medicare;
- the date the Dependent becomes covered under another group health plan;
- the date the policy is canceled.

For a spouse who is under age 55:

- 36 months from the date of (1), (2), (3) or (4) above or when coverage reduction or termination takes place within one year of the date the Employer files for protection under the bankruptcy provisions of Title 11 of the United States Code, whichever may occur first;
- the last day for which the required premium has been paid;
- the date the Dependent becomes entitled to Medicare;

- the date the Dependent becomes covered under another group health plan;
- the date the policy is canceled.

For a spouse who is age 55 or over:

- the date your former spouse becomes eligible for coverage under another group health plan;
- the date your former spouse becomes eligible for Medicare;
- the last day for which the required premium has been paid;
- the date the policy is canceled.

Notification and Election

Cigna will notify you (or in the case of divorce or legal separation, your former spouse) of the right to continue coverage within 30 days after receiving notice regarding loss of coverage. You and your Dependents (or in the case of divorce or legal separation, your former spouse) must submit an application and first premium payment no later than 45 days after notice of the right to continue coverage was sent.

Continuation of Medical Insurance – Group Plan Termination

If group medical coverage for you or your Dependents is canceled because the group plan terminates, coverage may be continued from the date of cancellation until the earliest of the following:

- 39 weeks from the date group coverage is canceled;
- the date the person fails to make a timely premium payment;
- the date the person becomes eligible for benefits under another group plan or under Medicare; or
- the date your Dependent ceases to qualify as a Dependent under the provisions of the plan.

Notification and Election

If the group plan terminates because of nonpayment of group premium, Cigna will notify you of your right to continue coverage within 30 days after the termination date. Termination of the group plan for nonpayment of premium will not occur before the expiration of any required grace period for premium payment.

You and/or your Dependents shall provide written notice of election together with the required premium within 31 days of the date of the notice.

If coverage for you and your Dependents ends because Cigna does not provide required notice of continuation, Cigna will be liable for any benefits payable during the lapse in coverage.

Special Continuation of Medical Insurance - Strike

If your Active Service ends due to strike, your insurance will be continued until the earliest of:

- 6 months past the date your active service ends;
- the date you fail to make a timely premium payment; or
- the date you become eligible for insurance under another group policy for medical benefits or Medicare.

Medical benefits only may be continued for an additional 12 months in accordance with federal law.

High Risk Pool

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

HC-TRM45

04-10

VI-ET

Definitions

Dependent

Dependents include:

- your lawful spouse of the same or opposite sex (including a partner to a civil union).

Please note: The rights of married persons under federal law may not be available to parties to a civil union.

HC-DFS248

04-10

VI-ET

Dependent – Applies to Vision Only

Dependents include:

- your lawful spouse; (including a partner to a civil union).

HC-DFS298

04-10

VI-ET1



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

CERTIFICATE RIDER – New Jersey Residents

Rider Eligibility: Each Employee who is located in New Jersey

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

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

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

HC-ETNJRDR

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
VI-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. Any In-Network deductible will be waived for childhood immunizations.

HC-COV42

04-10
VI-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 must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna 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-DFS646

01-15
VI-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
VI-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 made for or in connection with a Papanicolaou screening (Pap test) for women who are age 18, or older, when referred by a Physician, nurse practitioner, or certified nurse midwife.
- 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 insulin; syringes and needles; prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips; urine test strips; lancets and lancet devices; alcohol swabs; glucagon emergency kits and injectable glucagon.
- 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 consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of FDA approved contraceptive methods.
- charges made for contraceptive drugs and prescription appliances for contraception.

Nutritional Evaluation

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, dietitians 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.

HC-COV166

04-10
V2-ET

Definitions

Certification

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

HC-DFS476V2

05-12
ET

Covered Person

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

HC-DFS478

04-10
V2-ET

Culturally and Linguistically Appropriate Manner of Notice

The term Culturally and Linguistically Appropriate Manner of Notice means:

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

HC-DFS609 05-12
ET

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.

HC-DFS323 04-10
V1-ET

Grievant

The term Grievant means any of the following:

- A policyholder, subscriber, enrollee, or other individual, or that person’s authorized representative or provider, acting

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

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

HC-DFS477V2 05-12
ET

Health Benefits Plan

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

HC-DFS479V2 05-12
ET

Health Care Insurer

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

HC-DFS480 04-10
V2-ET

Health Care Professional

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

HC-DFS488 04-10
V2-ET

Health Care Services

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

HC-DFS481 04-10
V2-ET

Hearing Officer, Independent Co-Hearing Officer or ICO

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

HC-DFS482 04-10
V2-ET

Medical Necessity or Medically Necessary

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

HC-DFS483 04-10
V2-ET

Provider

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

HC-DFS484 04-10
V2-ET

Rescission of Coverage

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

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

HC-DFS608 05-12
ET

Termination of Coverage

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

HC-DFS485V2 05-12
ET

Traditional Fee-For-Service Indemnity Benefit

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

HC-DFS486V2 05-12
ET

Uniform Standards

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

HC-DFS487 04-10
V2-ET

Utilization Management Determinations

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

HC-DFS475 04-10
V2-ET

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

CERTIFICATE RIDER – 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.

HC-COV347 01-15
V1
HC-COV321 10-15
ET1

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.

HC-CNV32

01-15
VI-ET

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

CERTIFICATE RIDER – North Carolina Residents

Rider Eligibility: Each Employee who is located in North Carolina

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

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

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

HC-ETNCRDR

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 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-ELG1

04-10
V9-ET2

Covered Expenses

- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical

- services connected with surgical therapies (tubal ligations, vasectomies).
- charges made by a Hospital or Ambulatory Surgical Facility for anesthesia and facility charges for services performed in the facility in connection with dental procedures for: Dependent children below age 9; covered persons with serious mental or physical conditions; or covered persons with significant behavioral problems. The treating provider must certify that hospitalization or general anesthesia is required in order to safely and effectively perform the procedure because of the person's age, condition or problem.
 - charges made for or in connection with: the treatment of congenital defects and abnormalities, including those charges for your newborn child from the moment of birth; and with the treatment of cleft lip or cleft palate.
 - charges for prescription contraceptives and devices approved by the U.S. Food and Drug Administration and charges for the insertion and/or removal of a prescription contraceptive device and any Medically Necessary exam associated with use of the prescription contraceptive device.
 - charges for a qualified person for the diagnosis and evaluation of osteoporosis or low bone mass if at least 23 months have elapsed since the last Bone Mass Measurement was performed. More frequent follow up measurements will be covered when deemed Medically Necessary. Conditions that would be considered Medically Necessary include, but are not limited to: monitoring insureds on long-term glucocorticoid therapy of more than 3 months; or a central Bone Mass Measurement to determine the effectiveness of adding an additional treatment program for a qualified person with low bone mass as long as the Bone Mass Measurement is performed 12 to 18 months from the start date of the additional program.

Bone Mass Measurement (BMM) means a scientifically proven radiologic, radioisotopic, or other procedure performed on a qualified person to identify bone mass or detect bone loss in order to initiate or modify treatment.

A Qualified Person means one who:

- is estrogen deficient and at clinical risk for osteoporosis or low bone mass;
- is experiencing radiographic osteopenia anywhere in the skeleton;
- is receiving long-term glucocorticoid (steroid) therapy;
- is having primary hyperparathyroidism;
- is being monitored to assess the response to commonly accepted osteoporosis drug therapies;
- has a history of low-trauma fractures;

- has other conditions or is on medical therapies known to cause osteoporosis or low bone mass.
- charges made for surgical and nonsurgical care of Temporomandibular Joint Dysfunction (TMJ) excluding appliances and orthodontic treatment.

HC-COV119

04-10

V2-ET

Definitions

Dependent

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

HC-DFS700

07-14

VI-ET

Definitions

Dependent – Applies to Vision Only

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

HC-DFS256

04-10

VI-ET

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

CERTIFICATE RIDER – Ohio Residents

Rider Eligibility: Each Employee who is located in Ohio

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

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

The provisions set forth in this rider comply with the legal requirements of Ohio group insurance plans covering insureds

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

HC-ETOHRDR

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.

HC-ELG70

HC-ELG61

04-10

VI-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 two years for women ages 40 through 49, or an annual mammogram if a licensed Physician has determined the woman to be at risk; and an annual mammogram for women ages 50 through 64.
- 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. 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 or nurse-midwife in consultation with the mother. If you and your newborn receive at least 48 or 96 hours of inpatient stay following a vaginal or cesarean section, respectively, then coverage will be provided for physician-directed follow-up care that is determined Medically Necessary by the attending health care professionals. If you and your newborn are discharged earlier than the 48 or 96 hours described above, coverage will be provided for all Physician-directed follow-up care provided within 72 hours. Follow-up care shall include physical assessment of you and your newborn, parent

education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of clinical tests and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by the national organizations that represent pediatric, obstetric and nursing professionals. The coverage shall apply to services provided in your Physician's office or through home care visits. Home health care visits must be conducted by a provider who is knowledgeable and experienced in maternity and newborn care.

- charges for any drug approved by the Food and Drug Administration (FDA) which has not been approved by the FDA for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the Department of Health and Human Services (HHS) under 42 U.S.C. 1395x(t)(2), as amended, or in medical literature only if all of the following apply:
 - Two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed;
 - No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed;
 - Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the HHS pursuant to section 1861(t)(2)(B) of the "Social Security Act," 107 Stat. 591 (1993), 42 U.S.C. 1395x(t)(2)(B), as amended, as acceptable peer-reviewed medical literature.

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

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

- Require coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
- Require coverage for experimental drugs not approved for any indication by the FDA;

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

HC-COV123

HC-COV124

04-10

V1-ET1

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.

Eligible Cancer Clinical Trial means a cancer clinical trial that meets all of the following criteria:

- A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
- the treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
- the trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
- the trial does one of the following:
 - tests how to administer a health care service, item or drug for the treatment of cancer;
 - tests responses to a health care service, item or drug for the treatment of cancer;
 - compares the effectiveness of a health care service, item or drug for the treatment of cancer;
 - studies new uses of a health care service, item or drug for the treatment of cancer.
- the trial is approved by one of the following entities:
 - the National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
 - the United States Food and Drug Administration;
 - The United States Department of Defense; or
 - The United States Department of Veterans' Affairs.

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 nonparticipating 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-COV123

HC-COV124

04-10

V1-ET2

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 Insurance for Military Reservists and Their Dependents

If you are a Reservist, and if your Medical Insurance would otherwise cease because you are called or ordered to active military duty, you may continue Medical Insurance for

yourself and your Dependents, upon payment of the required premium to your Employer, until the earliest of the following dates:

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

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

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

Extension of Continuation to 36 Months

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

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

Provisions Regarding Notification and Election of Special Continuation

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

Special Continuation of Medical Insurance

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

- you have been insured under the policy (or under the policy and any similar group coverage replaced by the policy) during the entire 3 months prior to the date your Active Service ends; and
- you pay the Employer the required premium;

your Medical Insurance will be continued until:

- you become eligible for similar group medical benefits or for Medicare;
- the last day for which you have made the required payment;
- 12 months from the date your Active Service ends; or
- the date the policy cancels;

whichever occurs first.

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

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

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

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

Dependent Medical Insurance After Divorce

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

Conversion Available After Continuation

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

HC-TRM48

04-10
V1-ET

Termination of Insurance

Cancellation or Nonrenewal

Your coverage may be cancelled or nonrenewed by Cigna if you have performed an act or practice that constitutes fraud or intentional misrepresentation of material fact under the terms of your coverage and if the cancellation or nonrenewal is not based, either directly or indirectly, on any health status-related factor in relation to you.

HC-TRM92

04-10
V1-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
VI-ET

Definitions

Dependent

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

HC-DFS272

04-10
V2-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-ORMEPO-04-11

HC-ETORRDR

Eligibility – Effective Date

Exception to Late Entrant Definition

A person will not be considered a Late Entrant when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to other available coverage; Employer contributions toward the other coverage have been terminated; he no longer qualifies in an eligible class for prior coverage; or if such prior coverage was continuation coverage and the continuation period has been exhausted; and he enrolls for this coverage within 30 days after losing or exhausting prior coverage; or if he is a Dependent spouse or minor child enrolled due to court order, within 30 days after the order is issued.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective, on the date of marriage, birth, adoption, or placement for adoption.

An adopted child, or a child placed for adoption before age 19 will not be subject to any Pre-existing Condition limitation if such child was covered within 30 days of adoption or placement for adoption. Such waiver will not apply if 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Any applicable Pre-existing Condition limitation will apply to you and your Dependents upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

Pre-Existing Condition Limitation for Late Entrant

For plans which include a Pre-existing Condition limitation, the 6-month waiting period before coverage begins for such conditions, will be increased to 12 months for a Late Entrant.

For plans which do not include a Pre-existing Condition limitation, you may be required to wait until the next plan enrollment period, but no longer than 12 months, to enroll for coverage under the plan, if you are a Late Entrant.

For plans which do not standardly include a Pre-existing Condition limitation and which do not include an annual open



enrollment period, a Pre-existing condition limitation of 12 months will apply for a Late Entrant.

HC-ELGS

04-10
VI-ET

HC-ETPARDR

Covered Expenses

- charges made by a Physician for professional services including office visits for pregnancy.

HC-COV26

04-10
VI-ET2

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-DFS74

04-10
VI-ET1

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

CERTIFICATE RIDER – Pennsylvania Residents

Rider Eligibility: Each Employee who is located in Pennsylvania

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

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

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

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

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 or in connection with mammograms for breast cancer screening and diagnosis, not to exceed: a baseline mammogram annually for women age 40 and over; and a mammogram upon a Physician’s recommendation for women under age 40.
- charges for an annual gynecological exam, including a pelvic exam and a routine Pap smear. No dollar limit or deductible may be applied to routine Pap smears.
- charges for colorectal cancer screening for nonsymptomatic persons who are 50 years of age or older shall include, but not be limited to: an annual fecal occult blood test; a sigmoidoscopy, a screening barium enema or a test consistent with approved medical standards and practices to detect colon cancer, at least once every 5 years; and a colonoscopy at least once every 10 years.

Coverage for symptomatic persons shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating physician. “Symptomatic person” means an individual who experiences a change in bowel habits, rectal bleeding or persistent stomach cramps, weight loss or abdominal pain.

Coverage for a nonsymptomatic person at high or increased risk for colorectal cancer who is under 50 years of age shall include a colonoscopy or any combination of colorectal cancer screening tests in accordance with the American Cancer Society guidelines on screening for colorectal cancer published as of January 1, 2008. “Nonsymptomatic person at high or increased risk” means an individual who poses a higher than average risk for colorectal cancer.

- charges for childhood immunizations, including the immunizing agents and Medically Necessary booster doses.

Immunizations provided in accordance with Advisory Committee on Immunization Practices (ACIP) standards are covered for any insured person under age 21 and are exempt from deductibles or dollar limits.

- charges for Medically Necessary nutritional supplements for the treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia, and homocystinuria when administered under the direction of a Physician. Unless you are enrolled in a Health Savings Account or a High Deductible Health Plan, a deductible will not apply.
- charges for at least 48 hours of inpatient care following a mastectomy. A longer period of time will be covered if the treating Physician determines it is Medically Necessary. Home health care services will also be provided if the treating Physician deems these services Medically Necessary;
- The following benefits will apply to insulin-dependent, 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 glucometers; blood glucose monitors for the legally blind; insulin pumps; infusion devices and related accessories, including those adaptable for the legally blind; podiatric appliances; and glucagon emergency kits. A special maximum will not apply.
- charges for insulin; syringes; needles; 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 training by a Physician with expertise in diabetes management, but limited to the following:
 - Medically Necessary visits when diabetes is diagnosed;
 - Medically Necessary 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.

HC-COV136

04-10
V1-ET1

Definitions

Dependent

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

placement in your home, regardless of whether the adoption has become final.

HC-DFS276

01-15
V2-ET

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

CERTIFICATE RIDER – Rhode Island Residents

Rider Eligibility: Each Employee who is located in Rhode Island

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

HC-ETR1RDR

Important Notices

Rhode Island Mandatory Civil Unions Endorsement For Health Insurance

Purpose:

Rhode Island law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons. This endorsement is part of and amends this policy,

contract or certificate to comply with Rhode Island law.

Definitions, Terms, Conditions And Provisions

The definitions, terms, conditions and any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a civil union established according to Rhode Island law.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Rhode Island law.

Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a civil union established according to Rhode Island law.

"Dependent" means a spouse, party to a civil union established according to Rhode Island law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent upon the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Rhode Island law.

"Child" or "covered child" means a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent upon the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Rhode Island law.

Caution: Federal Rights May Or May Not Be Available

Rhode Island law 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 under federal law may not be available to parties to a civil union. For example, federal law, the Employee Retirement Income Security Act of 1974 known as "ERISA," controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

HC-IMP105

01-12

VI-ET

Covered Expenses

Home Health Services

Charges made for Home Health Services when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility.

Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

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 six home or office visits per month, three nursing visits per week, home health aide visits up to 20 hours per week, and the following services, as needed: physical, occupational or speech therapy as a rehabilitative service; respiratory service; medical social work; nutrition counseling; prescription drugs and supplies, such as dressings, bandages and casts; minor equipment such as commodes or walkers; laboratory testing; x-rays; and EEG and EKG evaluations. 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. 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-COV120

04-10
VI-ET

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

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

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

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;
- charges made for a drug that has been prescribed for the treatment of a specific type of cancer for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be covered, provided: the drug is recognized in any one of the following for the specific cancer treatment for which it has been prescribed: United States Pharmacopeia Drug Information; American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; or two articles from major peer-reviewed medical literature;
- 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 made for a mammogram once for women ages 35 to 39; once every two years for women ages 40 to 49; and once a year for women who are at least 50; and charges made for an annual Papanicolaou laboratory screening test;

The following benefits will be covered for treatment of diabetes mellitus:

- charges for podiatric appliances for prevention of complications associated with diabetes, blood glucose monitors, including for the legally blind, injection aids, insulin pumps and insulin infusion devices and accessories;
- charges for training by a Physician, but limited to the following:
 - visits certified by a Physician as Medically Necessary when diabetes is diagnosed;
 - visits which are certified by a Physician to be Medically Necessary following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management; and
 - visits which are certified by a Physician to be Medically Necessary for reeducation or refresher training.
- test strips for glucose monitors, visual reading and urine testing strips, insulin, cartridges for legally blind, syringes, glucagon emergency kits and oral agents for controlling blood sugar.

HC-COV126

04-10

VI-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-CNVI

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.

HC-DFS673

07-14
V2-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 – South Dakota Residents

Rider Eligibility: Each Employee who is located in South Dakota

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

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

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

HC-ETSRRDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns/Adopted Children

Any Dependent child born to or adopted by you while you are insured will become insured on the date of his birth or an adopted child from the start of the state's adoption bonding period if you elect Dependent Insurance no later than 31 days after his birth. Adjustment of premium will be done, if applicable, once the dependents are added after birth or start of the adoption period. If you do not elect to insure your Dependent 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-ELG1

04-10
V22-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

- Covered Expenses will include charges for Hospital Confinement of a mother and her newborn child for up to 48 hours following a vaginal delivery, or for up to 96 hours following a cesarean delivery. Any length of stay beyond the 48 or 96 hours will be covered if determined Medically Necessary. This will not prevent the mother and her newborn from being discharged earlier than 48 or 96 hours in accordance with the most recent AAP/ACOG "Guidelines for Perinatal Care", if the treating Physician determines that the mother and newborn meet the medical stability criteria outlined in the guidelines, and one postpartum home health care visit is authorized.
- for one postpartum home health care visit following discharge from the Hospital of the mother and newborn, if the mother and newborn are discharged prior to the 48 or 96 hours described above. Such visit will take place within 48 hours of discharge. Additional home health care visits may be covered if determined Medically Necessary, but are payable as any other home health care visit, subject to the plan terms and conditions. If the mother and newborn receive the full 48 or 96 hours of inpatient Hospital stay after delivery, Cigna is not required to also provide home health care visits. However, home health care will be authorized if it is determined as Medically Necessary.
- charges made for or in connection with mammograms for breast cancer screening and diagnosis, not to exceed: a base line mammogram for women ages 35 to 39; a mammogram every other year for women ages 40 to 49; and an annual mammogram for women age 50 and older.
- charges made by a Hospital or Ambulatory Surgical Facility (including a dental office) for anesthesia and facility charges for dental care provided to a covered Dependent age 4 or under or a covered person who is severely disabled or otherwise suffers from a developmental disability which places the person at serious risk, as determined by a Physician.

- charges made for treatment, including Day 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.
- charges for a diagnostic screening for prostate cancer including an annual diagnostic examination, including a digital rectal examination and a prostate-specific antigen test for: asymptomatic men age 50 and over; and men age 45 and over who are at high risk for prostate cancer. Coverage will also be provided for medically indicated diagnostic testing at intervals recommended by a Physician, including the digital rectal examination, prostate-specific antigen test and bone scan for males of any age who have a prior history of prostate cancer.
- charges for a drug that has been prescribed for the treatment of cancer or life threatening conditions for which use of the drug has not been approved by the U.S. Food and Drug Administration if that drug is recognized for treatment of the specific indication in one of the standard reference compendia or in accepted, peer reviewed medical literature. Coverage will also be provided for any medical services necessary to administer the drug.
- charges for equipment, pharmaceutical supplies, and outpatient self-management training and education, including medical nutrition therapy, prescribed for the treatment of diabetes. Coverage for medical nutrition therapy does not include food-items or non-prescription drugs.

Applied Behavioral Analysis

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

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

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

Cigna, at its own expense, may request a review of the ABA treatment being received, but not more than once every three

months, unless Cigna and the ABA provider agree to a more frequent review.

HC-COV428

05-15

VI-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

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

- for or in connection with an Injury or Sickness for which benefits are paid by worker's compensation.

HC-EXC162

06-15

V1 ET

Termination of Insurance

Special Continuation of Medical Insurance

If your coverage ends because your Employer ceased operations, failed to pay premiums, or canceled the policy and failed to notify you; and if:

- you have been insured under the policy during the entire 6 months prior to the date your coverage ended;
- you pay the Employer the required contribution; and
- you are not covered or eligible for Medicare, Medicaid, or other individual or group coverage; or any other coverage that would result in your being over insured according to Cigna;

you may apply for medical insurance continuation for yourself, and for any of your eligible Dependents, provided they were insured on the date your coverage ended.

You must apply in writing to your Employer*, and make the required monthly payment within 90 days after the date your coverage ends.

Your Medical Insurance continuation will be in effect until:

- you become insured for medical benefits under another group policy or under Medicare or Medicaid;
 - the end of the policy year you become eligible for medical benefits under another group policy or under Medicare;
 - the last day for which you have made the required payment; or
 - 12 months from the date your coverage ended;
- whichever occurs first.

Medical insurance continuation for your Dependents, subject to the provisions of this section, will be in effect until the earlier of:

- the date your insurance continuation coverage 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.

Continuation is not available if your coverage ended as a result of Cigna's minimum participation or eligibility requirements not being met.

Continuation is also not available if your coverage ended due to fraud or material misrepresentation in applying for benefits; or if Cigna withdraws from the insurance market in your state.

*If your Employer has ceased operations, you may apply and send payment to Cigna.

HC-TRM67

05-14

V2-ET

Definitions

Biologically-Based Mental Illness

A Biologically-Based Mental Illness is defined as: schizophrenia; and other psychotic disorders; bipolar disorder; major depression; and obsessive-compulsive disorder.

HC-DFS324

04-10

VI-ET

Late Entrant

You are a Late Entrant for Employee or Dependent Insurance if: you have declined medical coverage for yourself or your Dependents through your Employer during the initial enrollment period, or have ended your coverage at any time; and you later request coverage for yourself or your Dependents in a benefit plan of that Employer. The initial enrollment period must have been at least 30 days. An



individual is not considered a Late Entrant if one of the following applies:

- he meets all the following requirements: he was covered under another plan at the time of the initial enrollment; he will lose coverage under another plan as a result of a termination of employment or eligibility, the involuntary termination of previous coverage, death of a spouse or divorce; and he requests enrollment within 30 days of termination of coverage.
- the Employer offers multiple benefit plans and the individual elects a different plan during open enrollment.
- a request is made within 30 days of a court order for coverage to be provided for a spouse and dependent child.
- due to a change in a custody agreement, coverage for a child must be provided even if the agreement has not been included as a court order and the initial enrollment period must be at least 30 days.

HC-DFS325

04-10
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Tennessee Residents

Rider Eligibility: Each Employee who is located in Tennessee

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

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

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

HC-ETTNRDR

Covered Expenses

- charges 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.

HC-COV100

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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-ETTNRDR

CIGNA HEALTH AND LIFE INSURANCE COMPANY
Home Office: Bloomfield, Connecticut

**Mailing Address: 900 Cottage Grove Road
Hartford, Connecticut 06152**

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.

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

HC-IMP152

01-15

**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 – Exclusive Provider Plans

An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.

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 your insurer approves a referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the non-preferred provider’s bill so that you only have to pay any applicable coinsurance, copay and deductible amounts.

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 you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Cigna at the following toll-free telephone numbers for information or to make a complaint.

FOR MEDICAL INSURANCE QUESTIONS

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) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the agent or 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 someter una queja:

Usted puede llamar a Cigna a los siguientes números de teléfono para llamadas gratuitas si desea obtener información o someter una queja.

PARA PREGUNTAS ACERCA DEL SEGURO MEDICO

1-800-244-6224

Usted puede comunicarse Departamento de Seguros de Texas para obtener información sobre compañías, cobertura, derechos o quejas al

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si usted tiene una disputa con respecto a su prima o sobre un reclamo, usted debe comunicarse primero con el agente o la compañía. Si la disputa no se resuelve, usted puede entonces comunicarse con el Departamento de Seguros de Texas.

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

HC-IMP16

04-10

V2-ET

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.

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.
- 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 illness, provided that drug is Food and Drug (FDA) approved for at least one indication and is recognized for treatment in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or supported by articles in accepted, peer-reviewed medical literature. Coverage will also be provided for any medical services necessary to administer the drug.
- charges made for or in connection with one of the following non-invasive screening tests for atherosclerosis and abnormal artery structure and function. Coverage will be provided for computed tomography (CT) scanning measuring artery calcification; or ultrasonography measuring carotid intima-media thickness and plaque. Such coverage will be provided every five years for men ages 45-76 or women ages 55 to 76 who are diabetic or have a high risk of developing coronary heart disease based on a score derived using the Framingham Heart Study prediction algorithm that is intermediate or higher.
- charges made for all generally recognized services prescribed in relation to Autism Spectrum Disorder for Dependent children through age 9. 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.

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.

Biologically Based Mental Illness

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

Diabetes

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

Diabetes Equipment and Supplies:

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

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

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

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

- Nutrition and weight evaluation;
- Medications;
- An exercise regimen;
- Glucose and lipid control;
- High risk behaviors;
- Frequency of hypoglycemia and hyperglycemia;
- Compliance with applicable aspects of self-care;
- Follow-up on referrals;
- Psychological adjustment;
- General knowledge of diabetes;
- Self-management skills;
- Referral for a fundoscopic eye exam.

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

Clinical Trials

Charges made for routine patient care costs in connection with a phase I, II, III or IV clinical trial if the clinical trial is conducted in relation to the prevention, detection or treatment of a life threatening disease or condition. The clinical trial must be approved by: the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services; the National Institutes of Health; the U.S. Food and Drug Administration; the U.S. Department of Defense; the U.S. 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 U.S. Department of Health and Human Services.

HC-COV416

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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.

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-COV416

01-15
VI-ET2

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 Partial Hospitalization and Mental Health 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.

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.

HC-COV7

04-10
V5-ET

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. 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, 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.

HC-COV14

04-10
V2-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

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
VI-ET

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 with no break in coverage.

Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna 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-DFS414

04-10
V5-ET

Definitions

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

CERTIFICATE RIDER – Utah Residents

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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.

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HC-ETUTDR

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

v1

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.

HC-COV442

01-15
V1-ET3

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

HC-ETVTRDR

Definitions

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.

HC-DFS699

01-15
V1-ET1

Special Plan Provisions

Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide, or your Cigna HealthCare Directory, for a list of Participating Providers in your area. You can also call the toll-free number shown on the back of your ID card if you:

- have a question about a provider; or
- need help finding a Participating Provider; or
- desire an updated provider list.

Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs. Cigna does not offer any financial inducements to Participating Providers and facilities contracted in Vermont for the reduction or limitation of health care services.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card, or by calling us at our general Customer Service/Member Services number: 1-800-351-8513.

HC-SPP1

04-10
V2-ET

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

CERTIFICATE RIDER – Vermont Residents

Rider Eligibility: Each Employee who is located in Vermont

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.

Important Notices

Vermont Mandatory Civil Unions Endorsement for Health Insurance

Purpose:

Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons. This endorsement is part of

and amends this policy, contract or certificate to comply with Vermont law.

Definitions, Terms, Conditions and Provisions

The definitions, terms, conditions and any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as “marriage,” “spouse,” “husband,” “wife,” “dependent,” “next of kin,” “relative,” “beneficiary,” “survivor,” “immediate family” and any other such terms include the relationship created by a civil union established according to Vermont law.

Terms that mean or refer to the inception or dissolution of a marriage, such as “date of marriage,” “divorce decree,” “termination of marriage” and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

Terms that mean or refer to family relationships arising from a marriage, such as “family,” “immediate family,” “dependent,” “children,” “next of kin,” “relative,” “beneficiary,” “survivor” and any other such terms include family relationships created by a civil union established according to Vermont law.

“Dependent” means a spouse, party to a civil union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent upon the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

“Child” or “covered child” means a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent upon the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

Caution: Federal Rights May or May Not Be Available

Vermont law 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 under

federal law may not be available to parties to a civil union. For example, federal law, the Employee Retirement Income Security Act of 1974 known as “ERISA,” controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer’s enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under “COBRA” for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

HC-IMP26

04-10
V4-ET

Our Commitment to Quality

One of our goals is to work with network doctors to give you access to quality care and programs. The Cigna HealthCare Quality Management Program is based on industry standards and objective measures. These measures help us evaluate the quality of care and services you receive. The Quality Management Program helps us focus our improvement efforts where needed and allows for input from you, the customer, as well as network doctors. Improvement efforts are identified through regular analysis and the findings are reported to quality committees. Customers and network doctors serve on local health plan quality committees. The committees help us target areas in need of improvement and monitor change. Items included are:

- credentialing process for qualified doctors;
- ongoing assessment of clinical activities and services provided for you;
- Utilization Management activities and programs that serve you;

- program dedicated to communicating customer rights and responsibilities.

Your Role

Cigna HealthCare values your input and suggestions to improve care to our customers. Your participation in plan surveys gives us feedback on plan performance and policy developments.

You have the opportunity to provide input on our policies, serve on our health plan quality committee, or volunteer to participate in focus groups and surveys. Should you wish to provide feedback or receive more information about the Cigna HealthCare Quality Management Program, the annual program evaluation, chronic care or preventive health measures, or our progress in meeting goals, please call 800-591-9407 to leave a message to receive a return call.

HC-IMP26

04-10
V4-ET1

Specialist Physician Serving as Primary Care Physician for a Life-Threatening, Degenerative or Disabling Condition

In Vermont, a member may, upon Cigna approval, use a Specialist as their PCP for a life-threatening, degenerative or disabling condition. The request must include a signed statement from the member requesting the Specialist to serve as the member's PCP and certification from the Specialist of the medical need to serve as the member's PCP.

Upon receipt of this documentation:

- A Cigna Medical Director validates the Medical Necessity of the request.
- A decision is made within 10 business days or less from receipt of the request.
 - If approved, Cigna will reach out for a signed statement from the Specialist accepting responsibility to serve as the member's PCP, coordinate member care needs and accept the PCP contracted reimbursement rate for primary care services.
 - If the Cigna Medical Director denies the request for a Specialist to serve as the member's PCP, the denial notification includes the reason(s) for denial, appeal

rights and confirmation that the determination was made by a Cigna Medical Director.

- The member will be notified in writing within 21 to 30 business days of the decision.

Mailing Address:

Cigna HealthCare
4100 International Pkwy
Suite 1010
Carrollton, TX 75007

HC-IMP26

04-10
V4-ET2

Information Available to You Upon Your Request

Upon your request, by telephone or in writing to our Customer Service/Member Services office, we will provide you the information you need, if:

- you have a question about your coverage, your benefits, a provider, a claim, the services you received, a hospital stay, outpatient care; or
- you received a bill in error; or
- you have a complaint.

The following information is also available to you, if you call or write to Cigna. Or, you can log on to www.mycigna.com, and go to these pages: Provider Directory, Disclaimer, My Plans, and My Health.

- a list of providers and facilities;
- your coverage under this certificate, including a description of deductible, copayment and coinsurance amounts for which you are responsible;
- your plan's drug Formulary, if any;
- a description of the prior approval or utilization review process;
- the clinical review criteria used in making service denials;
- a description of financial benefits offered to any provider or facility for the reduction or limitation of health care services, if any;
- a description of the process for choosing and credentialing providers, including those handling utilization review;

- a description of the grievance procedures: all information related to the subject of grievance begun by you;
- a description of how to select, change or receive referrals to providers;
- access to your individual medical records, for which you will not be charged more than the cost to copy them;
- a summary of the quality assessment and improvement programs; and
- any other information that the plan makes available to you upon request.

To obtain a complete copy of your group insurance certificate form online, please log on to www.mycigna.com, and follow the instructions for using the “Cignaaccess” employer portal to request the certificate through your employer.

Translation Information

If English is not your primary language, we will provide you with information about your interactions with Cigna under the policy and this certificate, in your primary language. To request this information, call or write us at the toll-free number or address shown on the back of your ID card. We have bilingual representatives in Spanish-speaking areas. We also offer the Language Line service that can translate almost any other language.

Access to Your Physician

Cigna studies the availability of, and access to, our Participating Providers each year.

Wait Times

You should expect to get appointments with Participating Providers according to these standards:

- Emergency care appointments: immediately.
- Urgent care appointments: within 24 hours.
- Routine Physician appointments: within 2 weeks.
- Routine lab, X-ray and general optometry: within 30 days.
- Preventive care: within 90 days.

Travel Times

- You should not have to travel longer than 30 minutes, from home or work, for personal Physician services

and outpatient mental health/substance abuse treatment (if part of your healthcare plan).

- You should not have to travel longer than 60 minutes, from home or work, for prescription drugs, lab, X-ray and MRI services, eye exams, inpatient mental health treatment, and inpatient medical rehabilitation services.
- You should not have to travel longer than 90 minutes, from home or work, for kidney transplants, major trauma treatment, and open-heart surgery.

Description of Service Area

The network of Participating Providers and Participating Pharmacies established by Cigna is not limited to a defined geographical area near your home or work. Cigna maintains a national network of Participating Providers and Participating Pharmacies, to which you have access.

HC-IMP26

04-10
V4-ET3

The Schedule

Any deductible or coinsurance applicable to annual routine or diagnostic mammograms does not apply.

SCHED-VTET

Certification Requirements

The following provisions regarding how to request PAC apply if your medical certificate includes provisions for Pre-Admission Certification/Continued Stay Review:

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

To request PAC, or to obtain information on how to request PAC, you or your Dependent should call the toll-free number on the back of your ID card. For a non-emergency admission, the request should be at least four working days (Monday through Friday) prior to the schedule admission. If you are unable to call four days in advance, you should call as soon as you can. During your call, as for precertification, give us your ID number, and give us the facts regarding your Hospital stay.

The following provision regarding requesting an expedited review of a service requiring prior authorization or precertification applies if your medical certificate includes provisions for Pre-Admission Certification/Continued Stay Review for Hospital Confinement:

You or your Dependent may request an expedited review of a service requiring prior authorization or precertification, as described in the “Preservice Medical Necessity Determinations” provision of this certificate.

The following provision regarding requesting an expedited review of a service requiring prior authorization or precertification applies if your medical certificate includes provisions for Outpatient Certification Requirements:

Outpatient Certification Requirements

You or your Dependent may request an expedited review of a service requiring prior authorization or precertification, as described in the “Preservice Medical Necessity Determinations” provision of this certificate.

HC-PAC1

11-14
V17-ET

Prior Authorization/Pre-Authorized

Prior Authorization is not required for Emergency Services.

HC-PRA1

11-14
V7-ET

Covered Expenses

- charges made for or in connection with mammograms for breast cancer screenings, not to exceed an annual mammogram for women age 40 or over, or mammograms for women less than age 40 upon recommendation of a health care provider.

Cancer Clinical Trials

Routine patient care services directly associated with a patient’s participation in a phase I, II, III or IV approved cancer clinical trial.

An “approved cancer clinical trial” is an organized, systematic, scientific study of therapies, tests, or other

clinical interventions for purposes of treatment, palliation, or prevention of cancer in human beings.

The approved trial must:

- seek to answer a credible and specific medical or scientific question for the purpose of advancing cancer care;
- enroll only those patients for whom there is no clearly superior, noninvestigational treatment alternative;
- have available clinical or preclinical data that provides a reasonable expectation that the treatment obtained in the approved trial will be at least as effective as the noninvestigational alternative;
- be conducted under the auspices of one of the following Vermont cancer care providers: Vermont Cancer Center at Fletcher Allen Health Care, the Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center, or approved clinical trials being administered by a Vermont hospital and its affiliated, qualified Vermont cancer care providers;
- be conducted by a facility and personnel capable of conducting such a trial by virtue of experience, training and volume of patients treated to maintain such expertise;
- be conducted under the auspices of a peer-reviewed protocol that has been approved by one of the following entities: one of the National Institutes of Health (NIH); an NIH-affiliated cooperative group that is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer-review program operating within the group; the FDA in the form of an investigational new drug application or exemption; or the federal department of Veterans Affairs or Defense.

“Routine patient care services” are any Covered Expenses under this plan, including any Medically Necessary health care service that is incurred as a result of the treatment being provided to the patient for the purposes of the approved cancer clinical trial. Routine patient care services do not include the following:

- the cost of investigational new drugs that have not been approved for market for any indication by the FDA, or the costs of any drug being studied under an FDA-approved investigational new drug exemption for the purpose of expanding the drug’s labeled indications.

- the costs of nonhealth care services that may be required as a result of the treatment being provided for the purposes of the approved cancer clinical trial.
- the costs of the services that are clearly inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis and performed specifically to meet the requirements of the approved cancer clinical trial.
- the costs of any tests or services performed specifically to meet the needs of the approved cancer clinical trial protocol.
- the costs of running the approved cancer clinical trial and collecting and analyzing data.
- the costs associated with managing the research associated with the approved clinical trial.
- the costs for noninvestigational treatments or services that would not otherwise be covered under the patient's health benefit plan.
- any product or service paid for by the trial sponsor.

HC-COV70

04-10
VI-ET3

Prescription Drug Benefits

For You and Your Dependents

Cigna manages Prescription Drug Benefits. Procedures to do this may include Prescription Drug Lists, dose restrictions, prior authorization requirements, Step Therapy and drug substitution requirements. Pharmaceutical benefit management, with respect to particular drugs, may change frequently.

Please see our website at www.Cigna.com for the most current listing of Prescription Drug List drugs, or call the Customer Service/Member Services number on the back of your ID card. You can also get up-to-date Prescription Drug information by calling us at 1-800-835-3784.

Covered Expenses

When a change is made in Cigna's pharmaceutical benefit management that applies a new or revised dose restriction that causes a prescription for a particular drug not to be covered for the number of doses prescribed, or applies a new or revised substitution, Step Therapy, prior authorization or any other requirement that causes a particular drug not to be covered until the requirements

of that benefit management plan have been met, Cigna shall ensure:

- the change is published in the primary source of pharmaceutical benefit management information for you, your Dependents and providers as long in advance as possible but no less than 90 days prior to the effective date of the change;
- each covered person who is known to have an active prescription for the drug is individually notified in writing at least 90 days prior to the effective date of the change; and
- that if you or your Dependent request a fill or refill or a prescription written prior to publication of the change or receipt of the notice described above, the prescription remains valid; and if it is not possible to timely obtain a prescription consistent with the change requirement, coverage will be provided for an interim supply of the drug and, if relevant, any additional supply that is Medically Necessary to discontinue the drug for up to 90 days, or until the prescribing Physician can order a new prescription or, if necessary, until the grievance and independent review process can be initiated and completed. Cigna shall not be required to cover an interim supply if:
 - the covered person's prescribing Physician explicitly consents to the change; or
 - the drug has been determined to be unsafe for the treatment of the individual's disease or medical condition, or has been discontinued from coverage for safety reasons, or cannot be supplied by, or has been withdrawn from the market by, the drug's manufacturer.

HC-PHR28

04-10
VI-ET

Limitations

If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician should:

- call Cigna Pharmacy Services at (800) 244-6224; or
 - complete and fax the appropriate prior authorization form to Cigna Pharmacy Services at (800) 390-9745
- to provide information on the medication requested (name, strength and dosing schedule), the diagnosis

related to use, the duration of therapy, the Prescription Drug List alternatives tried, and any additional pertinent information (clinical reasons for the drug, relevant lab values, etc.). Your Physician should make this request before writing the prescription.

For information on Prescription Drugs and Related Supplies that require prior authorization, log on to www.mycigna.com and use the “Drug List” search tab, or see the “For Health” page. Or, call Customer Service/Member Services at the toll-free number on the back of your ID card.

If your Physician describes the request as relating to treatment needed on an urgent basis, your Physician will be notified of Cigna’s decision within 24 hours after the request. If the Physician’s request is for a non-urgent treatment situation, Cigna will notify the Physician of its decision within 15 days after 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 Drugs or Related Supplies should be covered. You may also request an expedited review of your appeal, as described in the “Preservice Medical Necessity Determinations” provision of this certificate.

As long as the drug continues to be prescribed for you or your Dependent and is considered safe for the treatment of the person’s condition, a person who has previously been prescribed an otherwise covered drug that is the subject of prior authorization, other review and/or denial shall be entitled to coverage for a supply of the drug sufficient to continue treatment through the following time periods, as well as any additional supply that is Medically Necessary to safely discontinue the drug if the denial is ultimately upheld:

- until Cigna has completed prior authorization or other review process;
- if applicable, until all required internal expedited grievances have been exhausted; and
- until the independent external review decision is issued, if expedited independent external review is requested within 24 hours of the receipt of the final grievance decision and notice of appeal rights by you or your Dependent, and expedited independent external review is conducted in accordance with the time frames specified by law.

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

A request for an exception to a pharmaceutical benefit management requirement or decision, including a requirement or decision relating to Step Therapy and Generic Drug issues, may be made in accordance with the “Prescription Drug Benefit Management Disclosure” provision of the When You Have a Complaint or an Appeal section of this certificate.

HC-PHR29

04-10

V1-ET

Exclusions, Expenses Not Covered and General Limitations

General Limitations

It is your responsibility to pay all charges for expenses incurred by you or any of your Dependents for:

- services and supplies that do not satisfy the certificate’s definitions of Covered Services; and
- services and supplies that are described as not covered in the Exclusions section of this certificate.

HC-EXC13

10-13

V2-ET

Medical Benefits Extension Upon Policy Cancellation

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

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group policy;
- the date you are no longer Totally Disabled;
- 12 months from the date your Medical Benefits cease; or

- 12 months from the date the policy is canceled.

Totally Disabled

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

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

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

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

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-BEX12

04-10
VI-ET

Definitions

Emergency Medical Condition

Emergency medical condition means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- placing the member's physical or mental health in serious jeopardy; or
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

HC-DFS446

11-10
VI-ET

Emergency Services

Emergency Services means health care items and services furnished or required to evaluate and treat an Emergency Medical Condition.

It is Cigna's responsibility, to:

- respond to, defend against and resolve any request, or claim, by a non-Participating Provider of Emergency Services for payment exceeding the amount it was paid or reimbursed by Cigna; and
- serve as the point of contact for you, if you receive any such request or claim by a non-Participating Provider. To obtain more information, you should call the toll-free number shown on the back of your ID card, or call us at our Customer Service/Member Services number at 1-800-351-8513.

HC-DFS393

11-10
VI-ET

Medically Necessary/Medical Necessity

Medically Necessary care means health care services, including diagnostic testing, preventive services and aftercare, that are appropriate in terms of type, amount, frequency, level, setting, and duration to the person's diagnosis or condition. Medically Necessary care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition; must be informed by the unique needs of each individual patient and each presenting situation; and:

- help restore or maintain the person's health; or
- prevent deterioration of, or palliate, the person's condition; or
- prevent the reasonably likely onset of a health problem or detect an incipient problem.

HC-DFS155

04-10
VI-ET



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

CERTIFICATE RIDER – Virginia Residents

Rider Eligibility: Each Employee who is located in Virginia

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

HC-ETVARDR

How To File Your Claim

Payment of Claim

All benefits payable under the Policy are payable within 40 days of receipt of proof of loss. All or any portion of any benefits may be paid to the health care services provider.

HC-CLM8

01-11
V2-ET

Termination of Insurance

Reinstatement of Medical Insurance

If your Medical Insurance ceases because of active duty in: the United States Armed Forces; the Reserves of the United States Armed Forces; or the National Guard, the insurance for you and your Dependents will be reinstated after your deactivation provided you apply for reinstatement and you are otherwise eligible.

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

period or Pre-existing Condition Limitation which existed prior to interruption of coverage may still be applied.

HC-TRM31

04-10
V1-ET

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

CERTIFICATE RIDER – Washington Residents

Rider Eligibility: Each Employee who is located in Washington

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

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

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

HC-ETWARDR

Notice

Coordination of Benefits Included – See Table of Contents for Location of Coordination of Benefits Section.

HC-CER1

02-16
V11-ET

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.

Your Right to Safe and Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please contact us (Cigna) at the number 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, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

Items to be Available on Request

You may 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.

HC-NOT72

ET

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 31 days, 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.

HC-ELG1

V25-ET

Certification Requirements

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

If your request for Experimental and Investigational treatment is denied, Cigna will notify you in writing within 20 working days. This review period will be extended beyond 20 working days only if you provide your informed written consent to Cigna.

PAC will not be required for mental health treatment rendered by a state hospital when you [or your Dependent] are involuntarily committed.

We will not retroactively deny coverage for:

- emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered; or
- care based on standards and protocols not communicated within a sufficient time for your Physician, healthcare provider or facility to modify care.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

HC-PAC44

VI-ET

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 patient's 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 laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- 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;
- diabetes supplies including insulin, 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.
- charges made for ABA therapy.
- charges made for a second 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;

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.

Nutritional Evaluation

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

- coverage for 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.
- charges made for or in connection with phenylketonuria.

HC-COV428

V3-ET1

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-ET

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 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-COV481

V2-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-DFSS71

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 must be submitted to Cigna within 31 days after the date the child ceases to qualify above. Cigna 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-DFSS673

V8-ET

Domestic Partner

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

HC-DFS47

V8-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, glucagon emergency kits), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

HC-DFS68

V7-ET