Rutherford County Employee Benefit Trust

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2024

ETEGWP24A
3321836

This document printed in February, 2024 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

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

CERTIFICATE RIDER

Policyholder: Rutherford County Employee Benefit Trust
Rider Eligibility: Each Employee as noted within this certificate rider
Policy No. or Nos.: 3321836
Effective Date: January 1, 2024

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

IMPORTANT INFORMATION

For Residents of States other than the State of Tennessee:

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

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

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

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

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

Geneva Cambell Brown, Corporate Secretary

HC-ETRDR

The Schedule

The pharmacy schedule is amended to add the following:

Covered prescription insulin drugs may not to exceed one hundred dollars ($100) per 30-day supply of the drug, without regard to the policy deductible, regardless of the amount or type of insulin needed to fill the prescription.

SCHEDPHARM90-alet

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

CERTIFICATE RIDER – Arizona Residents

Rider Eligibility: Each Employee who is located in Arizona

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

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

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

HC-ETAZRDR

Arizona

Important Notice

This notice is to advise you that you can obtain a replacement Appeals Process Information Packet by calling the Customer Service Department at the telephone number listed on your identification card for "Claim Questions/Eligibility Verification" or for "Member Services" or by calling 1-800-244-6224.

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

Provider Lien Notice

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

Notice

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

HC-IMP8 04-10
V1-ET

When You Have a Complaint or an Appeal

Start with Customer Service

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

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

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

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

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

Customer Services at the toll-free number that appears on your Benefit Identification card.

HC-APL277 10-16
ET

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

CERTIFICATE RIDER – Arkansas Residents

Rider Eligibility: Each Employee who is located in Arkansas

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

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

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

HC-ETARRDR

Important Notices

DISCLOSURE NOTICE

NOTICE: AS PERMITTED BY §23-79-803, THE POLICYHOLDER HAS SELECTED THIS PLAN WHICH DOES NOT PROVIDE COVERAGE IN ACCORDANCE WITH ONE, SOME OR ALL OF THE REQUIREMENTS FOR ONE OR MORE BENEFITS MANDATED BY THE STATUTES OF THE STATE OF ARKANSAS

STATE MANDATED BENEFITS NOT COVERED IN WHOLE OR IN PART ARE AS FOLLOWS:

Note: Refer to your Policy or Certificate of Insurance for details about covered expenses, non-covered expenses and limited covered expenses. Inclusion on this Disclosure Notice list may not mean that the benefit or service is not covered, but only that coverage may differ in some respect from the statutory requirements:

Arkansas Mental Health Parity Act, §23-99-501, et. Seq.

Prescription drug benefit, §23-79-149

Provisions generally, unlicensed professionals ("Freedom of Choice") §23-79-114 and Bulletin 9-85

You are urged to contact your health insurance agent or the Arkansas Insurance Department Consumer Affairs or Legal Division about questions or concerns related to the nature of the state mandated health benefit which is not provided in this health benefits plan.

HC-IMP24 04-10
V1-ET

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 90 days after his birth or the next premium due date, whichever is later. If you do not elect to insure your newborn child within such 90 days or by the next premium due date, whichever is later, coverage for that child will end on the 90th day. No benefits for expenses incurred beyond the 90th day will be payable.

HC-ELG183 12-17
ET2

Definitions

Prescription Drug Charge

The amount Cigna charges to the Plan, including the applicable dispensing fee and any applicable sales tax and prior to application of any Deductible, Copayment or Coinsurance amounts, for a Prescription Drug Product dispensed at a Network Pharmacy. For the purposes of Prescription Drug benefit payments, the "Plan" is the entity or business unit responsible for funding benefits in accordance with the terms and conditions outlined in this booklet/certificate.

HC-DFS1092 12-17
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

Prescription Drug Benefits

Exclusions

- charges made for a drug that has been prescribed for purposes other than those approved by the FDA unless:
  - the drug is otherwise approved by the FDA;
  - the drug is used to treat a life-threatening condition or, a chronic and seriously debilitating condition and the drug is Medically Necessary to treat that condition;
  - the drug has been recognized for the treatment prescribed by any of the following: the American Hospital Formulary Service Drug Information, one of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen; The Elsevier Gold Standard's Clinical Pharmacology; The National Comprehensive Cancer Network Drug and Biologics compendium; The Thomson Micromedix Drug Dex; or two articles from major peer reviewed medical journals that present data supporting the proposed use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

HC-PHR27 05-12
V2-ET

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

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

CERTIFICATE RIDER – Colorado Residents

Rider Eligibility: Each Employee who is located in Colorado

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

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

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

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

HC-ETCORDR

Eligibility - Effective Date

Exception for Children

Any Dependent child who was previously covered under Colorado's state program for children, the Children's Basic Health Plan, will not be considered a Late Entrant for Dependent Insurance if enrollment is requested within 90 days of the Dependent child's disenrollment or loss of eligibility under the program.

HC-ELG233 01-19
ET

Prescription Drug Benefits

Exclusions

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

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, Substance Use Disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of cancer in authoritative reference compendia as identified by the secretary of the U.S. Department of Health and Human Services.

HC-PHR458 01-21
ET

Expenses For Which A Third Party May Be Responsible

NOTE: *The plan may only place a lien on any recovery by the Participant that is in an amount in excess of the Participant's full compensation for all damages arising out of the claim.*

HC-SUB136 01-21
ET

Definitions

Dependent

Dependents include:

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

HC-DFS1667 01-22
ET

Emergency Service Provider

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

HC-DFS236 04-10
V1-ET

Employee

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

HC-DFS1096 01-18
ET1

Employer

The term Employer means the Policyholder and those affiliated employers whose Employees are covered under this Policy. The term Employer may include an Emergency Service Provider, any municipal or governmental corporation, unit, agency or department thereof, and the proper officers, as such, of an Emergency Service Provider or an unincorporated municipality or department thereof, as well as private individuals, partnerships, and corporations.

HC-DFS1594 01-21
ET

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

CERTIFICATE RIDER – Connecticut Residents

Rider Eligibility: Each Employee who is located in Connecticut

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

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

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

HC-ETCTRDR

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 01-15
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

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-DFS1314 01-19
ET

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

CERTIFICATE RIDER – Florida Residents

Rider Eligibility: Each Employee who is located in Florida

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

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

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

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

HC-ETFLRDR

Eligibility - Effective Date

Dependent Insurance

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included. For your Dependents to be insured for these benefits, you must elect the Dependent insurance for yourself no later than 30 days after you become eligible.

HC-ELG326 03-21
ET1

When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted. We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

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

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

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied, you can start the appeals procedure.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

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

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

Florida Adverse Determination Medical Necessity Appeal

To initiate an Adverse Determination appeal, you must submit a request in writing to Cigna within 30 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable to write, you may ask Cigna to assist so that you may register your written appeal. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form. Your appeal will be reviewed and the decision made by individuals not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by an Internal Panel of health care professionals. For appeals involving Medical Necessity or clinical appropriateness, the Internal Panel will include at least one Physician in the same or similar specialty as the care under consideration, as determined by the Cigna Physician reviewer. For Adverse Determination Medical Necessity Appeals, we will acknowledge in writing that we have received your request and schedule a panel review. For preservice and concurrent care coverage determinations, the panel review will be completed within 30 calendar days and for post service claims, the panel review will be completed within 60 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Internal Panel to complete the review. You will be notified in writing of the Internal Panel's decision within five working days after the panel considers your request.

Expedited Medical Necessity Appeal

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

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional. Please note that if you submit your written request within 30 days of receiving an initial denial notice, the Florida Adverse Determination Medical Necessity Appeal process described will apply. For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a post service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. If an issue does not qualify for the Expedited Medical Necessity Appeal process, you may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal. Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may present your situation to the Committee in person or by conference call. For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee

review will be completed within 15 calendar days. For post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage. If an issue does not qualify for the Expedited Medical Necessity Appeal process, you may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Appeal to the State of Florida

You have the right to contact the state regulators for assistance at any time. The state regulators may be contacted at the following addresses and telephone numbers:

The Statewide Provider and Subscriber Assistance Panel
Fort Knox Building One, Room 303
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456 or 850-921-5458
The Agency for Health Care Administration
Fort Knox Building One, Room 303
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456
The Department of Insurance
State Treasurer's Office
State Capitol, Plaza Level Eleven
Tallahassee, FL 32308
1-800-342-2762

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit. You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

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

Legal Action

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

HC-APL380 01-20
ET

Definitions

Dependent – For Medical Insurance

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of

an Injury or a Sickness existing prior to the date of placement or adoption. Coverage is not required if the adopted child is ultimately not placed in your home.

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

HC-DFS1685 01-23
ET

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

CERTIFICATE RIDER – Georgia Residents

Rider Eligibility: Each Employee who is located in Georgia

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

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

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

HC-ETGARDR

Prescription Drug Benefits

Exclusions

- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.

HC-PHR490 01-21
ET

When You Have A Complaint Or An Appeal

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

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

Start With Customer Service

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

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

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

Appeals Procedure

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

If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued

coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

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

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

Level One Appeal

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

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

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

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

Step Therapy Override Appeals

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

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

Level Two Appeal

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

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

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

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

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

You are entitled to a prompt and meaningful hearing for issues related to a denial, in whole or in part, of a health care service, treatment, or claim following exhaustion of all standard appeals requirements. The grievance hearing will be conducted by a panel of not less than 3 persons, including a Physician other than the medical director of the Plan, and a health care provider competent in the treatment or procedure which has been denied. You will be provided prompt notice in writing of the resolution. Immediate appropriate relief will be granted to you when the outcome is favorable to you. For adverse determinations, the notice will include specific findings related to the care, the policies, and procedures relied upon in making the determination, the Physician's and provider's recommendations, including any recommendations for alternative procedures or services, and a description of the procedures, if any, for reconsideration of the adverse decision.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The request for independent review may be submitted only by an insured, the parent or guardian of an insured who is a minor, or a legal guardian or representative of an insured who

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

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

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

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

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

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

Notice of Benefit Determination on Appeal

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

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

Relevant Information

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

Legal Action

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

Assistance from the State of Georgia

You have the right to contact the Department of Insurance or the Department of Human Resources for assistance at any time. The Department of Insurance or the Department of

Human Resources may be contacted at the following respective addresses and telephone numbers:

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

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

HC-APL395 01-20
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Illinois Residents

Rider Eligibility: Each Employee who is located in Illinois

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

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

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

HC-ETILRDR

Prescription Drug Benefits

Covered Expenses

Prescription Drug List Exceptions

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

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

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

- any request for approval of coverage made verbally or in writing (regardless of whether made using a paper or electronic form or some other writing) at any time shall be reviewed by appropriate health care professionals;
- within 72 hours after receipt of a request either approve or deny the request. In the case of a denial, Cigna shall provide you or your authorized representative and your Physician with the reason for the denial, an alternative covered medication, if applicable, and information regarding the procedure for submitting an appeal to the denial;
- an expedited coverage determination request must either be approved or denied within 24 hours after receipt of the request. In the case of a denial, Cigna shall provide you or your authorized representative and your Physician with the reason for the denial, an alternative covered medication, submitting an appeal to the denial.

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

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

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

Epinephrine Injectors

Coverage for Medically Necessary epinephrine injectors for persons 18 years of age or under.

HC-PHR567 01-22
ET

Limitations

Step Therapy

Step therapy is not required for medications used in the treatment of substance use disorders. Cigna will process these medications in compliance with the requirements of the law.

HC-PHR568 01-23
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
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Prescription Drug Benefits

Limitations

Prescription Eye Drops

Refill of prescription eye drops will be allowed when:

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

HC-PHR470 01-21
ET

Prescription Drug Benefits

Exclusions

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

HC-PHR544 01-22
ET1

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

CERTIFICATE RIDER – Kansas Residents

Rider Eligibility: Each Employee who is located in Kansas

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

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

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

HC-ETKSRDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 31 days after his birth. If you 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
V4-ET

Prescription Drug Benefits

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule. Your benefits may vary depending on which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

Coverage under your plan's Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure. Additionally, the plan shall provide coverage for psychotherapeutic Prescription Drug Products used for the treatment of mental illness on a basis no less favorable than coverage provided for other Prescription Drug Products.

HC-PHR314 01-19
ET

When You Have A Complaint Or An Appeal

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

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

Start with Customer Service

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

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

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

Appeals Procedure

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

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

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

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

We will respond in writing with a decision within 30 calendar days after we receive an appeal for a required preservice determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; (b) if the service has been determined experimental or investigational and the treating Physician certifies in writing, that the recommended or requested health care service or treatment for the medical condition would be significantly less effective if not promptly initiated or (c) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

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

Independent External Review Procedure

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

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

In order to request a referral to an Independent External Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. You may also request an external review if you have not received a final decision within 60 days of seeking an internal appeal review.

To request a review, you must notify the Kansas Commissioner of Insurance within 120 days of your receipt of Cigna's appeal review denial. Once the Commissioner has approved your request for external review, Cigna will forward the file to the selected Independent External Review Organization.

The Independent External Review Organization will render an opinion within 30 days. When a delay would be detrimental to your condition, you may request an expedited external review. If approved, the Independent External Review Organization shall complete the review not more than 72 hours after the date of receipt of the request for an expedited external review or as expeditiously as the medical condition or circumstances require.

Appeal to the State of Kansas

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

Kansas Insurance Department
420 SW 9th Street
Topeka, KS 66612-1678
Toll Free Number: 1-800-432-2484

Notice of Benefit Determination on Appeal

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

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

Relevant Information

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action in federal court under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna in federal court until you have completed the Appeals processes. In all events, such suit or proceeding must be commenced no later than five (5) years after the date from the time written proof of loss is required to be given.

HC-APL246 09-14
V1-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

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.

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

Important Information

If the following text regarding "If Cigna determines….required to pay." is included in your **Important Information** section of your certificate, it does not apply to you.

Coupons, Incentives and Other Communications

If Cigna determines that a Pharmacy, pharmaceutical manufacturer or other third party is or has waived, reduced, or

forgiven any portion of the charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Prescription Drug Product without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of plan benefits in connection with the Prescription Drug Product, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the Pharmacy, pharmaceutical manufacturer or other third party represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by the plan.

For example, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a Prescription Drug Product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.

HC-IMP298 V1 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

When You Have A Complaint or an Appeal

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

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

Start With Member Services

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

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

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

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

Appeals Procedure

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

Level-One Appeal

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

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

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

Level-Two Appeal

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

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

For level-two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 5 working days after the Committee meeting,

and within the Committee review time frames above if the Committee does not approve the requested coverage.

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

Independent Review Procedure

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

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

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

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

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by Cigna's Physician reviewer, the review shall be completed within 3 days.

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

Appeal to the State of Louisiana

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

Louisiana Department of Insurance
1702 North Third Street
P.O. Box 94214
Baton Rouge, LA 70804-9214
800-259-5300 (Toll Free within Louisiana)
225-342-5900

Notice of Benefit Determination on Appeal

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

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

Relevant Information

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

Legal Action

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

HC-APL23V1 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

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

CERTIFICATE RIDER – Maine Residents

Rider Eligibility: Each Employee who is located in Maine

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

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

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

HC-ETMERDR

Important Notices

Important Notice Regarding Cancellation of Coverage

This notice is to advise you that you have the right to designate a third party to receive notice of cancellation of your coverage under this plan.

Designation of Third Party to Receive Notice

If you would like to designate a third party to receive notice of cancellation of your coverage, you can call Customer Service at 1-800-244-6224 or the phone number shown on your ID card. Customer Service will send to you a "Third Party Notice Request Form," which you should complete and return to your Employer or Plan Administrator, as appropriate.

You also have the right to change the person or party you have designated to receive notice of cancellation of your coverage. A request to change designation should be made in writing to your Employer or Third Party Administrator.

Right to Reinstatement for Insureds with Organic Brain Disease

Should your coverage be cancelled, you have the right to have your coverage reinstated if:

- you suffer from an organic brain disease; and
- the reason your coverage cancelled was because you did not pay your premium or because of another lapse or default on your part.

"Organic brain disease" means a mental or nervous disorder with a demonstrable organic origin, causing significant cognitive impairment, including, but not limited to:

- Pick's Disease;
- Parkinson's Disease;
- Huntington's Chorea; and
- Alzheimer's Disease and related dementias.

HC-IMP49 04-10
V1-ET

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

CERTIFICATE RIDER – Maryland Residents

Rider Eligibility: Each Employee who is located in Maryland

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

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

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

HC-ETMDRDR

Important Notices

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You, your child's noninsuring parent, a state child support enforcement agency or the Maryland Department of Health and Mental Hygiene must notify your Employer and elect coverage for that child. If you yourself are not already enrolled, you must elect coverage for both yourself and your child. We will enroll both you and your child within 20 business days of our receipt of the QMCSO from your Employer.

Eligibility for coverage will not be denied on the grounds that the child: was born out of wedlock; is not claimed as a dependent on the Employee's federal income tax return; does not reside with the Employee or within the plan's service area; or is receiving, or is eligible to receive, benefits under the Maryland Medical Assistance Program.

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Claims

Claims will be accepted from the noninsuring parent, from the child's health care provider or from the state child support enforcement agency. Payment will be directed to whomever submits the claim.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

Termination of Coverage Under a QMCSO

Coverage required by a QMCSO will continue until we receive written evidence that: the order is no longer in effect; the child is or will be enrolled under a comparable health plan which takes effect not later than the effective date of disenrollment; dependent coverage has been eliminated for all Employees; or you are no longer employed by the Employer,

except that if you elect to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage will be provided for the child consistent with the Employer's plan for postemployment health insurance coverage for Dependents.

HC-IMP89 04-10
V1-ET4

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

The Schedule

The pharmacy schedule is amended to add the following:

Generic FDA approved tobacco cessation products are not subject to the deductible, copay or coinsurance.

SCHEDPHARM90-maet

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
V1-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 stepchild who lives with you; and
- 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-DFS1686 01-23
ET

Prescription Drug Product

The following diabetic supplies: blood glucose monitoring strips for home use, urine glucose strips, ketone strips, lancets, insulin, insulin syringes, prescribed oral diabetes medications that influence blood sugar levels, insulin pumps and insulin pump supplies, insulin "pens".

HC-DFS1831 01-24
ET

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-ETMIRDR

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
V1-ET

Prescription Drug Benefits

Limitations

Prescription Eye Drops Refills

If the following conditions are met the refill prescription will be covered:

(a) For a 30-day supply, once 23 days have passed after either of the following:
- The original date the prescription was distributed to you.
- The date the most recent refill was distributed to you.

(b) The prescriber indicates on the original prescription that additional quantities are needed.

(c) The prescription eye drops prescribed by the prescriber are covered under the plan.

HC-PHR375 01-20
ET

Definitions

Prescription Drug Product

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

- The following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Glucagen, needles including pen needles, syringes;
- Medication used in the treatment of the feet, ankles or nails associated with diabetes;

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

HC-DFS958 10-16
ET

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

CERTIFICATE RIDER – Mississippi Residents

Rider Eligibility: Each Employee who is located in Mississippi

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

HC-ETMSRDR

Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

Coverage includes charges for a drug that has been prescribed for the treatment of a type of cancer 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 cancer for which the drug has been prescribed in any one of the following reference compendia: United States Pharmacopeia Drug Information; American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; or one article in a U.S. peer-reviewed national medical journal; the drug has been otherwise approved by the FDA; and its use for the specific type of cancer treatment prescribed has not been contraindicated by the FDA.

HC-PHR6 04-10
V3-ET

Prescription Drug Benefits

Exclusions

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

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

  The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of the prescribed indication in US Pharmacopoeia Drug Information or American Hospital Formulary Service Drug Information, or in two articles from major peer-reviewed professional medical journals, unless two articles from major peer-reviewed journals have determined that the drug is unsafe or ineffective, or that drug safety and effectiveness cannot be determined for the prescribed treatment.

HC-PHR442 01-21
ET

Termination of Insurance

Special Continuation of Medical Insurance

If your insurance ceases due to termination of employment for any reason other than fraud or nonpayment of any required premium or, regarding a covered Dependent, the death of the Employee, divorce from the Employee, or failure of a Dependent child to qualify as a Dependent and:

- you or your Dependent has been insured under the policy (and any similar group coverage replaced by the policy) for at least 3 consecutive months immediately prior to the date of termination; and
- you or your Dependent is not eligible for other insured or uninsured coverage within 31 days following the date of termination; and
- you or your Dependent is not covered under Medicare, although a Dependent of an Employee who elects Medicare is eligible to continue coverage;

you or your Dependent may continue the insurance by paying the required premiums to the Policyholder. In no event will the insurance be continued beyond the earliest of the following dates:

- the expiration of 12 months from the date the insurance would otherwise terminate;
- the last day for which you or your Dependent has paid the required premium;
- the date you or your Dependent becomes eligible for insured or uninsured group medical coverage or elects Medicare, although a Dependent of an Employee who elects Medicare is eligible to continue coverage;
- the date the group policy is canceled; or
- the date a surviving or divorced spouse remarries and becomes covered for medical benefits under a health plan with no pre-existing condition limitations.

Notice Requirements

For Employees and Dependents upon termination of employment or ineligibility of Employee class, Cigna will send notice of the right to continue coverage prior to termination of coverage. For Dependents upon Employee death, Employee entitlement to Medicare, divorce, or loss of eligibility as a Dependent child, your Employer will send notice of the right to continue within 14 days after being notified of any event above. You must elect to continue coverage within 30 calendar days of receiving notice of the right to continue.

HC-TRM52 04-10
V1-ET

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

CERTIFICATE RIDER – Missouri Residents

Rider Eligibility: Each Employee who is located in Missouri

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

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

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

HC-ETMORDR

Important Notices

Missouri First Steps Program

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

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

Missouri Utilization Review Decisions and Procedures

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

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

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

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

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

When conducting utilization review or making a benefit determination for emergency services, Cigna shall cover emergency services necessary to screen and stabilize a covered person and shall not require prior authorization of such services. Before denying payment for an emergency medical service based on the absence of an emergency medical condition, Cigna shall review the enrollee’s medical record regarding the emergency medical condition at issue. If Cigna requests records for a potential denial where emergency services were rendered, the provider shall submit the record of the emergency services within 45 processing days. Such review shall be completed by a Missouri board-certified Physician. When a covered person receives an emergency service that requires immediate post evaluation or post stabilization services, Cigna shall provide an authorization decision within 60 minutes of receiving a request; if the authorization decision is not made within 60 minutes, such services shall be deemed approved.

A written notification of an adverse determination shall include the principal reason or reasons for the determination, including the clinical rational, and the instructions for initiating an appeal or reconsideration of the determination. Cigna shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to the provider and to any party who received notice of the adverse determination. Requests for appeal includes an appeal for coverage of Medically Necessary pharmaceutical prescriptions and durable medical equipment.

Cigna shall have written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. These procedures shall be made available to providers on Cigna's website or provider portal. In cases where the provider or a covered person will not release necessary information, Cigna may deny certification of an admission, procedure or service.

If an authorized representative of Cigna authorizes the provision of health care services, Cigna shall not subsequently retract its authorization after the health care services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless such authorization is based on a material misrepresentation or omission about the treated

person's health condition or the cause of the health condition, the health benefit plan terminates before the health care services are provided or the covered person's coverage under the health benefit plan terminates before the health care services are provided.

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

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

Termination of Insurance

Special Continuation of Medical Insurance

For Dependents of Deceased Employee

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

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

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

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

When You Have A Complaint Or An Appeal

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

We want you to be completely satisfied with the care and services you receive. That is why we have established a

process for addressing your concerns and solving your problems.

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number at 1-800-Cigna24 and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service toll-free number or write us at the address that appears on your Benefit Identification card, explanation of benefits or claim form.

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

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

Appeals Procedure

Cigna has a two step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

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

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us our toll-free number 1-800-Cigna24 or at the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

If Cigna fails to strictly adhere to all the requirements of the internal claims and appeals process, you may initiate an external Independent Review and/or pursue any available remedies under applicable law.

Level One Appeal

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

For level one appeals, we will respond in writing with a decision within 7 calendar days in the case of a prospective review, and 30 days in the case of a retrospective review after the date in which on which we received the grievance request for review. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 7 calendar days and to specify any additional information needed to complete the review.

The time period for making a determination and receiving notification may be extended one time for up to 7 business days if we determine,

1) that an extension is necessary due to matters beyond Cigna's control; and
2) you are notified prior to the expiration of the initial 7-business-day period, of the circumstances requiring the extension of time and of the date by which we expect to make a determination.

If the extension is necessary because you failed to submit information necessary to reach a determination on the request, the notice of extension will,

1) describe specifically the required information necessary to complete the request; and
2) provide you or your authorized representative at least 45 days after the date of receipt of the notice to provide the specified information.

If Cigna receives a request that fails to meet filing procedures, you will be notified of this failure, and any information regarding the proper procedures to be followed for filing a request will be included in the notice. The notice will be provided as soon as possible but no later than 3 days after the date of the failure. Cigna may provide the notice orally or in writing (if requested), or electronically. This rule is only applicable to communication that is sent by you (or your personal representative) and received by a person or an organizational unit of Cigna responsible for handling benefit matters; and refers to you, a specific medical condition or symptom, and a specific health care service, treatment, or health care provider for which certification is being requested.

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

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

Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 48 hours, followed up in writing. If the request for an expedited appeal is not received as a written request, Cigna will respond with a decision by written confirmation within 48 hours.

Level Two Appeal

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

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

For required preservice and concurrent care coverage determinations, Cigna's review will be completed within 15 calendar days. For postservice claims, Cigna's review will be completed within 7 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. You will be notified in writing of the decision within five working days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

You may request that the appeal process be expedited if: the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 48 hours, followed up in writing.

Expedited Appeal Process

An expedited review may be requested by you or your authorized representative orally, in writing, or electronically. On receipt of a request for an expedited review, Cigna may appoint one or more Physicians or health care professionals of the same licensure to review the adverse determination. An appointed Physician or health care professional of the same licensure may not have been involved in making the initial adverse determination.

In an expedited review, all necessary information, including the decision, will be transmitted between you, Cigna or, if applicable your authorized representative in the most expeditious method available, whether by telephone, facsimile, or other method.

The timeframe for making a decision under an expedited review will be no more than 48 hours after the receipt of the request for the expedited review.

If you have failed to provide sufficient information for the Cigna to make a determination, you will be notified either orally or, in writing (if requested), or electronically of this failure and informed of what specific information is needed. This notification will be made as soon as possible but not later than 24 hours after receipt of the request.

Cigna, taking into account the circumstances, will provide you with a reasonable period of time to submit the necessary information. The reasonable period will not end less than 48 hours after you are notified or, if applicable, your authorized representative of the failure to submit sufficient information.

You will be notified with respect to the urgent care request as soon as possible but not later than 24 hours after the earlier of; 1) Cigna's receipt of the requested information; or 2) the end of the period provided for you to submit the requested information.

If you fail to submit the information before the end of the period of the extension Cigna may deny the certification of the requested benefit.

If the Cigna's determination is an adverse determination, notice of the adverse determination will be provided.

Independent Review Procedure

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

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

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

The Independent Review Organization will render an opinion within 45 days. When requested and when if: a delay would be

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

Appeal to the State of Montana

You have the right to contact the State Auditor's Office Insurance for assistance at any time. The Commissioner may be contacted at the following address and telephone number:

The Montana State Auditor's Office
Insurance Division
840 Helena Avenue
Helena, MT 59601
1-800-332-6148
406-444-2040

Notice of Benefit Determination on Appeal

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

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

Relevant Information

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action.

HC-APL432 01-21
ET

Definitions

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 – Nevada Residents

Rider Eligibility: Each Employee who is located in Nevada

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

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

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

HC-ETNVRDR

Important Notices

Nevada Division of Insurance

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

The Department of Business Industry, Division of Insurance

Toll free number: (888) 872-3234

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

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

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

HC-IMP48 04-10
V2-ET

When You Have A Complaint Or An Appeal

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

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

Start with Customer Service

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

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

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

Appeals Procedure

Cigna has a two step Appeals Procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. You can call us at the Customer Service toll-free number that appears on your Benefit Identification card, explanation of benefits or claim form, or you can write to us at the following address:

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

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

Level One Appeal

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

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

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

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

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

Level Two Appeal

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

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

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

You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

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

Independent External Review Procedure

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

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

You may, within four months after receiving notice of the adverse determination, submit a request to the Office for Consumer Health Assistance for an external review of the adverse determination. Within five days after receiving a request, the Office for Consumer Health Assistance shall notify you and Cigna that the request has been filed and shall assign an Independent Review Organization.

Within five days after receiving notification specifying the Independent Review Organization assigned, Cigna will provide all documents and materials relating to the adverse determination.

The Independent Review Organization shall, within five days after receiving the request notify you and Cigna if any additional information is required to conduct a review of the adverse determination. Such additional information must be provided within five days. The Independent Review Organization will approve, modify or reverse the adverse determination within 15 days after it receives the information required to make that determination.

Expedited Independent External Reviews

The Office for Consumer Health Assistance will approve or deny a request for an external review of an adverse determination in an expedited manner not later than 72 hours after it receives proof from the provider of health care of the covered person that: the adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from the facility providing the services or care; or failure to proceed in an expedited manner may jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function.

If the Office for Consumer Health Assistance approves a request for an external review then it will assign the request to

an Independent Review Organization not later than one business day after approving the request. Within 24 hours after receiving notice assigning the request, Cigna will provide to the Independent Review Organization all required documents and materials.

An Independent Review Organization that is assigned to conduct an external review will: complete its external review not later than 48 hours after receiving the assignment, unless the covered person and Cigna agree to a longer period; not later than 24 hours after completing its external review, notify the covered person, the Physician of the covered person, the authorized representative, if any, and Cigna by telephone of its determination; and not later than 48 hours after completing its external review, submit a written decision of its external review to the covered person, the Physician of the covered person, the authorized representative, if any, and Cigna.

External Review - Experimental or Investigational

Within four months after receipt of a notice of an adverse determination that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, you may file a request for external review with the Office for Consumer Health Assistance. You may make an oral request for an expedited external review if the covered person's treating Physician certifies, in writing, that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

Within one business day after receipt of a request for external review the Office for Consumer Health Assistance shall notify Cigna. Within five business days after receipt of the notice, Cigna will complete a preliminary review to determine if the request meets the requirements for review.

Within one business day after completion of the preliminary review, Cigna will notify the Office for Consumer Health Assistance and you whether the request is: complete; eligible for external review; not complete, in which case the health carrier shall include in the notice the information or materials that are needed to make the request complete; or not eligible for external review, in which case the health carrier shall include in the notice the reasons for its ineligibility.

The notice of initial determination must include a statement that a request which is ineligible for external review may be appealed to the Office for Consumer Health Assistance, and the Office for Consumer Health Assistance may determine that a request for an expedited external review is eligible for external review.

If Cigna determines that a request is eligible for external review, it will notify the Office for Consumer Health Assistance and you within one business day after receipt of the notice from Cigna that the external review request is eligible for external review, the Office for Consumer Health Assistance will: assign an Independent Review Organization to conduct the external review; notify Cigna of the name of the assigned Independent Review Organization; and notify you in writing that the request is eligible for external review and provide the name of the assigned Independent Review Organization.

The notice will include a statement that you may submit in writing to the assigned Independent Review Organization within five business days additional information that the Independent Review Organization will consider when conducting the external review. The Independent Review Organization may accept and consider additional information submitted after the five business days have elapsed.

Within five business days after receipt of the notice, Cigna will provide to the assigned Independent Review Organization any documents and information considered in making the adverse determination. If Cigna fails to provide the documents and information within five business days, the assigned Independent Review Organization may terminate the external review and make a decision to reverse the adverse determination. If the Independent Review Organization elects to terminate the external review and reverse the adverse determination, the Independent Review Organization will immediately notify you, if applicable, Cigna and the Office for Consumer Health Assistance.

Within 20 days after receipt of the opinion of each clinical reviewer assigned to review the case, the assigned Independent Review Organization will make a decision and provide written notice of the decision to you, Cigna, and the Office for Consumer Health Assistance.

Expedited External Reviews - Experimental or Investigational

Upon receipt of a request for an expedited external review, the Office for Consumer Health Assistance shall immediately notify Cigna, and Cigna will immediately determine whether the request meets the requirements for review. Cigna will immediately notify the Office for Consumer Health Assistance and you of its determination regarding eligibility. The notice of initial determination must include a statement that a request which is ineligible for external review may be appealed to the Office for Consumer Health Assistance, and the Office for Consumer Health Assistance may determine that a request for an expedited external review is eligible for external review. If the expedited external review meets the requirements for review, the Office for Consumer Health Assistance will immediately assign an Independent Review Organization and notify Cigna of the name of the assigned Independent Review Organization. Cigna will provide or transmit any documents and information considered in making the adverse determination to the assigned Independent Review Organization electronically or by telephone or facsimile, or any other available expeditious method. Within 48 hours after

receipt of the opinion of each clinical reviewer the assigned Independent Review Organization will make a decision and provide notice of the decision orally or in writing to you, Cigna and the Office for Consumer Health Assistance. If the notice provided was not in writing, within 48 hours after providing that notice, the assigned Independent Review Organization will provide written confirmation of the decision to you, Cigna, and the Office for Consumer Health Assistance.

Final Decision

If the determination of an Independent Review Organization concerning an external review of an adverse determination is in favor of the covered person, the determination is final, conclusive and binding upon Cigna. Cigna will immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination. The cost of conducting an external review of an adverse determination will be paid by Cigna.

Assistance from the State of Nevada

You have the right to contact the Consumer Service Section for assistance at any time. The Consumer Service Section may be contacted at the following address and telephone number:

For Carson City:
1818 E. College Parkway
Carson City, NV 89706
1-888-872-3234

For Las Vegas:
3300 W. Sahara Ave, Suite 275
Las Vegas, NV 89102
1-888-872-3234

Notice of Benefit Determination on Appeal

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

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

Relevant Information

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

Legal Action

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

HC-APL379 01-20
ET1

Definitions

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

Domestic Partner

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

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

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

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

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

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

HC-DFS709 01-15
ET

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

CERTIFICATE RIDER – New 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

Notice

This certificate, issued in New Hampshire, is under the jurisdiction of the New Hampshire Commissioner of Insurance, and is governed by New Hampshire law.

HC-IMP111 04-10
V1-ET

Prescription Drug Benefits

For You and Your Dependents

Limitations

You or any one of your Dependents can purchase up to a 90-day supply of covered prescription drugs on the Prescription Drug List at one time, provided that you can demonstrate that you have been taking the drug for a continuous period of one year and the drug is not subject to prior authorization or precertification requirements. Controlled substances as identified by the United States Drug Enforcement Administration are exempt from this requirement.

HC-PHR36 04-10
V1-ET

If coverage for a non-formulary Prescription Drug is denied and your medical condition is such that waiting for the standard appeal process to be completed would seriously jeopardize your ability to regain maximum function, you may be eligible for an expedited review. Cigna will complete expedited reviews within 48 hours of receiving clinical rationale for the exception from the prescribing physician.

If you have questions about a specific Prescription Drug List exception or prior authorization request, you should call Member Services at the toll-free number on the ID card or 1-800-244-6224.

HC-PHR34 04-10
V1-ET

When You Have A Complaint Or An Appeal

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

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

Start with Customer Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, or a rescission of coverage, you can call our toll-free number 1-800-244-6224 and explain your concern to one of our Customer Services representatives. Please call at the Customer Services toll-free number 1-800-244-6224 or the number that appears on your Benefit Identification card, explanation of benefits or claim form.

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

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

Appeals Procedure

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

Cigna
National Appeals Unit (NAU)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call at the toll-free number 1-800-244-6224 or the number on your Benefit Identification Card, explanation of benefits or claim form.

If Cigna fails to strictly adhere to all the requirements of the internal claims and appeals process, you may initiate an external Independent Review and/or pursue any available remedies under applicable law.

Level One Appeal

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

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a post-service coverage determination.

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

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

Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing within 2 business days.

You have the right to proceed directly to external review if we do not issue a level one appeal decision within any of the above stated time frames. See the provision "Independent Review Procedure" for information on how to request an external appeal.

Level Two Appeal

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

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

For required preservice and concurrent care coverage determinations, Cigna's review will be completed within 15 calendar days and for post-service claims, Cigna's review will be completed within the 30 day time period from the initial date of filing the appeal or grievance. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level-two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

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

You may request that the appeal process be expedited if: the time frames under this process would seriously jeopardize your life, health or your ability to regain maximum functionality; or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital Stay. Cigna Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing within 2 business days.

You have the right to proceed directly to external review if we do not issue an expedited level two appeal decision within the stated time frames. See the provision "Independent Review Procedure" for information on how to request an external appeal.

Independent Review Procedure

New Hampshire law gives you the right to an external appeal when health care services are denied by Cigna on the basis that the services are not Medically Necessary or that the services are experimental or investigational.

What is an External Appeal?

- An external appeal is a request that you make to the state for an independent review of a denial of services by Cigna.
- Reviews are conducted by Independent Review Organizations (IROs) that are accredited by the state and have a network of medical experts to review Cigna's denial of services.
- You must complete the Request for Independent External Appeal of a Health Care Decision application form, which can be obtained by calling the toll-free number that appears on your benefit identification card or 1-800-244-6224, and submit the application and all supporting documentation to the New Hampshire Insurance Department to request an external appeal.

Appeal to the State of New Hampshire

You have the right to contact the New Hampshire Department of Insurance for assistance at any time. The Commissioner's Office may be contacted at the following address and telephone number:

New Hampshire Insurance Department
Commissioner's Office
21 South Fruit Street, Suite 14
Concord, New Hampshire 03301
1-800-852-3416

When Is My Appeal Eligible For Independent External Review?

To be eligible for independent external review the following conditions must be met:

- The service that is the subject of the appeal request must be a covered benefit under the terms of your health insurance policy or at least something that could be a covered benefit in some circumstances.
- You must have completed the internal appeal process provided by your insurer and received a final decision from your insurer. However, this requirement need not be met if your insurer agrees in writing to submit its decision to independent external review prior to completion of internal review. In addition, if you have requested first or second level internal review and have not received a decision from your insurer within the required time frames, you may proceed to external review without having received a decision from your insurer on internal review. You must exhaust all internal appeal options available to you to qualify for external review.
- You must submit your request for independent external review to the New Hampshire Insurance Department within 180 days of the date that you were first eligible to file for review. Normally, this will be the date of the health insurer's written, second-level denial decision on internal review.
- Your request for an independent external review must not be for the purpose of pursuing a claim or allegation of health care provider malpractice, professional negligence, or other professional fault.

Types of Health Insurance For Which External Review Is Not Available

In general, independent external review is available only for private, managed care health insurance coverage. Service denials related to the following types of insurance coverage or health benefit programs are not reviewable under New Hampshire's external review law:

- Medicaid, the State Children's Health Insurance Program, Medicare, or services provided under these programs but through a contracted insurer.
- all other government-sponsored health insurance or health service programs.
- health benefit plans that are self-funded by employers.

Can Someone Else Represent Me In My External Appeal?

Yes, you may designate anyone you would like, including your treating health care provider, to represent you. To do so, you must fill out the section of the external appeal request form entitled, "Appointment of Authorized Representative." You may also revoke this authorization at any time.

Filing the External Appeal

You, or someone acting on your behalf with your written consent, may request an independent external review by filling out the external appeal request form, which can be obtained by calling the toll-free number that appears on your Benefit Identification card or 1-800-244-6224, and submitting it to the New Hampshire Insurance Department together with the required supporting documentation. There is no cost to you for an external review. Please be sure to include all of the following with your appeal:

- a completed external appeal request form.
- a copy (if you received one) of the letter from your health insurer denying your request at the second and final level of the internal appeal process.
- a photocopy of your insurance card or other evidence that you are insured by the health insurance company named in your external appeal request form.
- a copy of your certificate of coverage or your insurance policy benefit booklet, which lists your benefits.
- any medical records, statements from your treating health care providers, or other information that you would like the independent review organization to consider in reviewing you case.

You may call the Insurance Department at 800-852-3416 or 603-271-2261 if you need help with the application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for independent external review.

If you are requesting a standard appeal, send all paperwork to:

Independent External Review
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301-7317

1-800-852-3416

If you are requesting an expedited appeal, call the Insurance Department before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

What Is the Standard Appeal Process and Time Frame?

- Within 7 business days after receiving your request for an independent external review, the Insurance Department will complete a preliminary review to determine whether your request is complete and whether your case is eligible for external review. If the request is not complete, the Insurance Department will inform you or your representative what information or documents are needed to make the request complete and to process the request. You will have 10 days to supply the needed information or documents.
- If the request for external review is accepted, the Insurance Department will select and retain an independent review organization to conduct the review and notify you and the insurer.
- Within 10 days after receiving notice of the acceptance of the appeal, the insurer must provide the selected independent review organization and you all the information in its possession that is relevant to the appeal. You, or your representative, will then have another 10 days to submit new or additional information to the independent review organization and the insurer if you would like. During this 10-day period, you or your representative may also present oral testimony via teleconference to the independent review organization and the insurer. However, oral testimony will be permitted only in cases when the commissioner determines that it would not be feasible or appropriate to present only written information. If you or your representative would like to discuss your case with the independent review organization and your insurer by telephone conference, you can request this by checking the appropriate box in the external appeal request form or by contacting the Insurance Department no later than 10 days after receiving notice of the acceptance of the appeal.
- At the end of this second 10-day period, the record of the case will be closed and no new information may be provided. The independent review organization will then have 20 days to review all of the information and documents received and render a decision upholding or reversing the determination of the insurer.

Expedited External Review

Because the standard process for handling external review can take over 47 days, expedited (fast-tracked) external review is available for those persons who would be significantly harmed by having to wait. You may request expedited review by checking the appropriate box on the appeal request form and by having your treating health care provider fill out a certification form, which is attached to the appeal request form, verifying the adherence to the time frame for standard review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. Expedited review must be completed in at most 72 hours.

If you are pursuing an internal appeal with your insurer and anticipate that you may be requesting external review on an expedited basis, please call the Insurance Department at 800-852-3416 or 603-271-2261 in advance, so that accommodation can be made to receive and process your request as quickly as possible.

What Happens When an Independent Review Organization Makes Its Decision?

- If your appeal was expedited, in most cases you and your health insurer will be notified of the independent review

organization's decision immediately by telephone or fax. Written notification will follow.

- If your appeal was not expedited, you and your health insurer will be notified in writing.
- The decision of the independent review organization is binding on the health insurer and is enforceable by the Insurance Department. The decision is binding on you as well, except that it does not prevent you from pursuing any other claim or remedy you may have under federal or state law.

If you have any questions, please contact the New Hampshire Insurance Department at 800-852-3416 or 603 271-2261 and ask to speak to a consumer assistant.

Additional information regarding the External Appeal process can be obtained at the New Hampshire Insurance Department web site at:

http://www.nh.gov/insurance

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision. **If the notice is not initially provided in writing, then within 2 business days of receiving that notice you will also receive written confirmation of the decision that includes the information noted above.** You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review.

Relevant Information

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

Legal Action

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

No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with Cigna. No action will be brought at all unless brought within 2 years after the time within which proof of loss is required.

HC-APL60 04-10
V1-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.

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

CERTIFICATE RIDER – New Jersey Residents

Rider Eligibility: Each Employee who is located in New Jersey

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

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

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

HC-ETNJRDR

Important Notice

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

HC-IMP17 04-10
V1-ET

Definitions

Dependent

Dependents include:

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

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

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

HC-DFS978 01-17
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – New Mexico Residents

Rider Eligibility: Each Employee who is located in New Mexico

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

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

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

Consumer Complaint Notice

If you are a resident of New Mexico, your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If you have concerns regarding a claim, premium, or other matters relating to this coverage, you may file a complaint with the New Mexico Office of Superintendent of Insurance

(OSI) using the complaint form available on the OSI website and found at: https://www.osi.state.nm.us/ConsumerAssistance/index.aspx.

HC-ETNMRDRV3

When You Have a Complaint or an Appeal (Grievance)

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

Information about Appeals (Grievance) Procedures

Cigna is responsible for:

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

Timeframes for Initial Utilization Management Determinations

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

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

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

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

Before Cigna denies a Health Care Service requested by a Provider or Grievant on grounds of a lack of Medical Necessity, a Physician shall render an opinion as to Medical Necessity, either after consultation with specialists who are

experts in the area that is the subject of review, or after application of Uniform Standards used by Cigna. The Physician shall be under the clinical authority of the medical director responsible for Health Care Services provided to Grievants.

Notice of Initial Utilization Management Determination

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

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

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

Customer Service

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

When You Have a Complaint or an Appeal (Grievance)

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

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

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

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

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

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

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

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

Adverse Determination Appeal

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

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

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

Administrative Appeal

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

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

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

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

Internal Appeal of an Adverse Determination

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

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

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

We will ensure that all internal claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions in such a way that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert), must not be made based upon the likelihood that the individual will support the denial of benefits.

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

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

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

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

Adverse Determination Appeal

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

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

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

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

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

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

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

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

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

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

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

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

Internal Panel Appeal of Adverse Determination

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

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

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

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

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

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

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

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

You have the right to:

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

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

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

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

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

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

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

The written notice will contain:

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

External Review of Adverse Determination Procedure

If you are dissatisfied with the results of an internal panel review, you may request, at no cost to you, an external review by the Superintendent. There is no minimum claim dollar amount that must be met before you exercise this right to external review.

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

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

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

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

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

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

Cigna will bear the cost of the external review.

The request shall be:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Both you and Cigna have the right to:

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

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

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

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

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

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

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

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

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

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

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

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

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

Administrative Appeal (Grievance) Procedures

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

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

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

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

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

The written decision shall contain:

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

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

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

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

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

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

You have the right to:

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

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

- information sufficient for you to identify the claim;
- the names, titles, and qualifications of the persons on the reconsideration committee;
- the reconsideration committee's statement of the issues involved in the administrative appeal;
- a clear and complete explanation of the rationale for the reconsideration committee's decision;
- the Health Benefits Plan provision relied on in reaching the decision;
- references to the evidence or documentation relied on in reaching the decision;
- a statement that the initial decision will be binding unless you submit a request for external review by the Superintendent within twenty (20) working days of receipt of the reconsideration decision; and
- a description of the procedures and deadlines for requesting external review by the Superintendent, including any necessary forms.

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

External Review of Administrative Appeal by Superintendent

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

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

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

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

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

The request shall either be:

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

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

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

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

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

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

Confidentiality

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

HC-APL105 05-12
V3-ET

Definitions

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

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-ELG243 01-19
ET

Prescription Drug Benefits

Retail Participating Pharmacies can fill your prescription for a 90 day supply at the same Coinsurance or Copayment that applies to the home delivery Participating Pharmacy Prescription Drugs.

HC-ETEGWP-RX 02-14

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
V1-ET

Prescription Drug Benefits

Exclusions

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

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, Substance Use

Disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

The plan or policy shall not limit or exclude coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy (a) it is recognized as safe and effective for the specific treatment prescribed according to any of the following: The AMA Drug Evaluations; The American Hospital Formulary Service; The US Pharmacopoeia Dispensing Information; or two articles from major peer-reviewed professional medical journals which meet the journalistic standards of the International Committee of Medical Journal Editors or the U.S. Department of Health and Human Services, if those articles are not contradicted by evidence presented in another article from such a journal; (b) it has been otherwise approved by the FDA; and (c) it has not been contraindicated by the FDA for the use prescribed. The law does not prohibit health plans from using drug formularies. The law does require coverage for any medical services necessary to administer a drug.

Prescription Drug Benefits

Exclusions

No payment will be made for the following expenses:

- 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-PHR46 04-10
V3-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

How To File A Claim

Time Of Payment

Claims, either paper or electronic, will be paid by Us within 30 calendar days of receipt. However, if more time is needed to make a determination due to matters beyond Our control, We will notify You or Your representative within 30 days after receiving your claim. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the claim. The determination period will be suspended on the date Cigna sends such a notice of missing information, and resume on the date You or Your representative responds to the notice.

HCDFB-CLM78 06-21
ET

Definitions

Dependent

The term Dependent means:

- any unmarried child of Yours who is:
  - less than 99years old.
  - 99 or more years old,and primarily supported by You and incapable of self-sustaining employment by reason of mental or physical impairment which arose while the child was covered as a Dependent under this Plan, or while covered as a Dependent under a prior plan with no break in coverage of more than 63 days. Proof of the child's condition and dependence may be required to be submitted to Us within 31 days after the date the child ceases to qualify above.

The term child means a child born to You or a child legally adopted by You. It also includes a stepchild who lives with You, or a child supported pursuant to a court order imposed on You (including a Qualified Medical Child Support Order).

HCDFB-DFS335 06-21
V2-ET

Prescription Drug Benefits

Limitations

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee’s clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

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

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

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

Synchronization means the coordination of medication refills for a patient taking two or more medications for one or more

chronic conditions such that the patient's medications are refilled on the same schedule for a given time period.

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

HC-PHR468 01-21
ET

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

CERTIFICATE RIDER – Oklahoma Residents

Rider Eligibility: Each Employee who is located in Oklahoma

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

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

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

HC-ETOKRDR

Prescription Drug Benefits

Limitations

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee’s clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

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

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

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

Synchronization means the coordination of medication refills for a patient taking two or more medications for one or more chronic conditions such that the patient's medications are refilled on the same schedule for a given time period.

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

HC-PHR468 01-21
ET

When You Have a Complaint or an Appeal

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

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

Start with Customer Service

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

You can also express that concern in writing. Please call us at the Customer Services toll-free number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

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

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

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

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

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

If Cigna does not adhere to internal claim and appeals processes, including responding within regulatory timeframes, you can be deemed to have exhausted the process, and can proceed to external review, if available, and pursue other remedies under the law as applicable.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by an Oklahoma licensed Physician.

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

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

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

Level Two Appeal

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

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

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

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

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

(b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

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

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

In order to request a referral to an Independent Review Organization, certain conditions apply.

The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process; if you are requesting a standard external review, send all paperwork to:

Oklahoma Insurance Department
External Review
Triad II, 7645 E 63rd
7645 E 63rd Street, Suite 102
Tulsa, OK, 74113

If you are requesting an expedited external review, call the Insurance Department at 800-522-0071 or 405-521-2828 before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

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

Assistance from the State of Oklahoma

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

Oklahoma Insurance Department
Five Corporate Plaza
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112 -4511
Toll Free: 1-800-522-0071

Notice of Benefit Determination on Appeal

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

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

Relevant Information

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most

instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action.

HC-APL370 01-20
ET1

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-ETORRDR

Definitions

Dependent

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

HC-DFS1067 10-16
ET1

Definitions

Dependent

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

HC-DFS1007 10-16
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

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

Prescription Drug Benefits

Exclusions

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

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” sections of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

  The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug of Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of the prescribed indication in one of the following: United States Pharmacopoeia Drug Information; American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; or two articles from major peer-reviewed medical literature.

HC-PHR566 01-22
ET

The Following Will Apply To Residents Of South Carolina

When You Have A Complaint Or An Appeal

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

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

Start with Customer Service

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

Customer Service toll-free number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

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

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

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by

applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

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

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

Level One Appeal

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

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

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

Level Two Appeal

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

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

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 5 working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

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

External Review Procedure

You filed an appeal pursuant to Cigna’s level one or level two processes and Cigna has not issued a written decision within the time frames for making a decision if Cigna has received all the information needed to complete the appeal review and you have not agreed to a delay.

Cigna has agreed to waive the completion of the level one or level two appeal processes.

To request a review, you must notify the Appeals Coordinator within 60 days of your receipt of Cigna's level two appeal denial. To request an expedited external review, you must notify the Appeals Coordinator within 15 days of your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Review Organization. Cigna will review all newly submitted information to determine if the appeal can be approved before being sent to the Independent Review Organization.

The Independent Review Organization will render an opinion on standard external review within 45 days. An expedited external review shall be completed as expeditiously as possible, but no later than within three days.

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

Assistance from the State of South Carolina

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

South Carolina Department of Insurance
1201 Main Street, Suite 1000
Columbia, SC 29201
803-737-6160

Notice of Benefit Determination on Appeal

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

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

Relevant Information

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action.

HC-APL369 01-20
ET1

Definitions

Dependent

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

HC-DFS981 10-16
ET

Emergency Service/Emergency Medical Condition

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

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

HC-DFS263 04-10
V1-ETC

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

CERTIFICATE RIDER – 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-ETSDRDR

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 pharmacy Schedule is amended to indicate the following:

You may receive coverage for up to a 90-day supply of a covered Prescription Drug Product dispensed by a Retail Network Pharmacy or a Home Delivery Network Pharmacy. The amount you pay for a up to 90-day supply of a Prescription Drug Product at a Retail Network Pharmacy or a Home Delivery Network Pharmacy will be 3X the Copay for a 30-day supply at a Retail Network Pharmacy and the same Coinsurance as a Retail Network Pharmacy.

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

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

SCHED90EQ-sdet

Prescription Drug Benefits

Exclusions

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

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

HC-PHR575 01-22
ET

Prescription Drug Benefits

Retail Participating Pharmacies can fill your prescription for a 90 day supply at the same Coinsurance or Copayment that applies to the home delivery Participating Pharmacy Prescription Drugs.

HC-ETEGWP-RX 02-14

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

When You Have A Complaint Or An Appeal

(Review Of Grievance Or Adverse Determination)

For the purposes of this section, any reference to "you" or "your" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted; and "Physician Reviewers" are licensed Physicians depending on the care, treatment or service under review.

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

Start with Customer Service

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

Customer Services toll-free number that appears on your benefit identification card, explanation of benefits or claim form.

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

any case on the earlier of 20 working days or 30 calendar days.

If you are not satisfied with the results of a coverage decision, you can file an appeal following the appeals procedure outlined herein and you do not have to start with Customer Service.

Internal Appeals Procedure

Cigna has a single level internal appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal in writing within 180 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

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

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

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

We will respond in writing with a decision for:

Single Level Pre-Service Administrative and Medical Necessity appeals: Within 30 calendar days of receipt of appeal request.

Single Level Post Service Medical Necessity appeals: Within 30 calendar days of receipt of appeal request.

Single Level Post Service Administrative appeals: Within 60 calendar days of receipt of appeal request.

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

Cigna's Physician Reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 24 hours, followed up in writing within 3 calendar days.

Independent External Review Procedure

If we have denied your request for the provision of, or payment for, a health care service or course of treatment, you may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested. You or your Authorized Representative may submit a request for external review to the South Dakota Division of Insurance, 124 South Euclid Avenue, 2nd Floor, Pierre, South Dakota 57501. Except for a request for an expedited external review, all requests for external review must be made in writing to the director. The assignment by the director of an approved IRO to conduct an external review will be done on a random basis among those approved IROs qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to applicable South Dakota law. You or your Authorized Representative may request that your appeal be referred to an IRO at any time during the four months after the date of receipt of a notice of an adverse determination or final adverse determination. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

Cigna will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and when a delay would be detrimental to your condition, as determined by Cigna's Physician Reviewer, the review shall be completed within 72 hours.

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

Assistance from the State of South Dakota

You have the right to contact the South Dakota Division of Insurance for assistance at any time. The Director may be contacted at the following address and telephone number:

South Dakota Division of Insurance
124 S. Euclid Ave., 2nd Floor
Pierre, SD 57501
Telephone: 605-773-3563

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and will include: the titles and qualifying credentials of the reviewers; a statement of the

reviewers' understanding of the covered person's grievance; the reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position; a reference to the evidence or documentation used as the basis for the decision.

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

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

Relevant Information

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

Legal Action

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

HC-APL383 01-20
ET1

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

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

CERTIFICATE RIDER – Texas Residents

Rider Eligibility: Each Employee who is located in Texas

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

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

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

HC-ETTXRDR

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-244-6224

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

1-800-252-3439

You may write the Texas Department of Insurance:

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

Web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

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

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

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

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

1-800-244-6224

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

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

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

Web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

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

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

HC-IMP211 03-17
ET

Prescription Drug Benefits

Covered Expenses

Prescription Drug List Management

Your plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. Determination of inclusion of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and decides whether utilization management requirements or other coverage conditions are based on a number of factors which may include clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. Regardless of its eligibility for coverage under the plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

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

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the

coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy (ies) for coverage, or try another covered Prescription Drug Product(s). Please access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

Cigna shall limit changes to the Prescription Drug List that negatively impacts enrollees to the plan's renewal date. Changes to the Prescription Drug List that negatively impact enrollees include removing a Prescription Drug Product from the Prescription Drug List, moving a Prescription Drug Product to a higher cost-share tier or adding a prior authorization, step therapy or quantity limit requirement to the Prescription Drug Product. Cigna may, however, add Prescription Drug Products to the Prescription Drug List, move Prescription Drug Products to a lower cost-share tier or remove any prior authorization or other utilization management requirements from a Prescription Drug Product during the plan year. You will receive at least sixty (60) days notice of any Prescription Drug List change for which Cigna is required to provide notice to enrollees.

HC-PHR638 01-23
ET

Prescription Drug Benefits

Exclusions

- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law. Coverage does include formulas necessary for the treatment of phenylketonuria (PKU) or other inheritable diseases and medications or supplements used to address symptoms of autism spectrum disorder.

HC-PHR663 01-23
ET

Prescription Drug Benefits

Limitations

Prior Authorization Requirements

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

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

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

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

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

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

Step Therapy

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

Supply Limits

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

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

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

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

Prescription Eye Drops

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

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

HC-PHR447 01-21 ET

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness, except for expenses related to other benefits plans that provide insurance coverage for the Participant (excluding Part B of Medicare).
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement,

judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist insurance (to the extent such Participant or the Participant's immediate family did not pay the premiums associated with the foregoing types of insurance coverage), or homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Right Of Reimbursement

If a Participant incurs a Covered Expense for which another party may be responsible or for which the Participant may receive payment as described above, the plan is granted a right of reimbursement, to the extent of the benefits provided by the plan, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

Lien Of The Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan, except for reasonable fees and pro rata shares of expenses incurred in connection with the recovery action to be paid to the Participant's attorneys pursuant to an agreement between the plan and those attorneys or amounts awarded by a court to the Participant's attorneys that constitute reasonable fees for the recovery of proceeds for the plan (not to exceed one-third of the plan's recovery amount). This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in the pursuit of its right of recovery. The plan's recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

- Participants must assist the plan in pursuing any recovery rights by providing requested information.

HC-SUB85 10-16

When You Have A Complaint Or An Adverse Determination Appeal

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

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

When You Have a Complaint

We are here to listen and help. If you have a complaint regarding a person, a service, the quality of care, a rescission of coverage, or contractual benefits not related to Medical Necessity, you can call our toll-free number and explain your concern to one of our Customer Service representatives. A complaint does not include: a misunderstanding or problem of misinformation that can be promptly resolved by Cigna by clearing up the misunderstanding or supplying the correct information to your satisfaction; or you or your provider's dissatisfaction or disagreement with an adverse determination. You can also express that complaint in writing. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form, or write to us at the following address:

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

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your complaint, we will send you a letter acknowledging the date on which we received your complaint no later than the fifth working day after we receive your complaint. We will respond in writing with a decision 30 calendar days after we receive a complaint for a post service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

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

Cigna's Physician reviewer, or your treating Physician, will decide if an expedited appeal is necessary. When a complaint is expedited, we will respond orally with a decision within the earlier of: 72 hours; or one working day, followed up in writing within 3 calendar days.

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

Complaint Appeals Procedure

To initiate an appeal of a complaint resolution decision, you must submit a request for an appeal in writing to the following address:

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

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

Your complaint appeal request will be conducted by the Complaint Appeals Committee, which consists of at least three people. Anyone involved in the prior decision, or subordinates of those people, may not vote on the Committee. You may present your situation to the Committee in person or by conference call.

We will acknowledge in writing that we have received your request within five working days after the date we receive your request for a Committee review and schedule a Committee review. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer or your treating Physician will decide if an expedited appeal is

necessary. When an appeal is expedited, we will respond orally with a decision within the earlier of: 72 hours; or one working day, followed up in writing within three calendar days.

When You Have an Adverse Determination Appeal

An Adverse Determination is a decision made by Cigna that the health care service(s) furnished or proposed to be furnished to you is (are) not Medically Necessary or clinically appropriate. An Adverse Determination also includes a denial by Cigna of a request to cover a specific prescription drug prescribed by your Physician. If you are not satisfied with the Adverse Determination, you may appeal the Adverse Determination orally or in writing. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. We will acknowledge the appeal in writing within five working days after we receive the Adverse Determination Appeal request.

Your appeal of an Adverse Determination will be reviewed and the decision made by a health care professional not involved in the initial decision.

We will respond in writing with a decision within 30 calendar days after receiving the Adverse Determination appeal request.

You may request that the Adverse Determination Appeal Process be expedited if it relates to: (a) emergency denials, (b) denials of care for life-threatening conditions, (c) denials of continued stays for hospitalized enrollees; and (d) denial of prescription drugs or intravenous infusions for which the Member is receiving benefits under the Agreement; or (e) step therapy requests.

Cigna's Physician reviewer or your treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within the earlier of: 72 hours; or one working day, followed up in writing within three calendar days.

In addition, your treating Physician may request in writing a specialty review within 10 working days of our written decision. The specialty review will be conducted by a Physician in the same or similar specialty as the care under consideration. The specialty review will be completed and a response sent within 15 working days of the request. Specialty review is voluntary. If the specialty reviewer upholds the initial adverse determination and you remain dissatisfied, you are still eligible to request a review by an Independent Review Organization.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's Adverse Determination appeal process or if you feel your condition is life-threatening, you may request that your appeal be referred to an Independent Review Organization. In addition, your treating Physician may request in writing that Cigna conduct a specialty review. The specialty review request must be made within 10 days of receipt of the Adverse Determination appeal decision letter.

Cigna must complete the specialist review and send a written response within 15 days of its receipt of the request for specialty review. If the specialist upholds the initial Adverse Determination, you are still eligible to request a review by an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

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

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. You will receive detailed information on how to request an Independent Review and the required forms you will need to complete with every Adverse Determination notice.

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

Appeal to the State of Texas

You have the right to contact the Texas Department of Insurance for assistance at any time for either a complaint or an Adverse Determination appeal. The Texas Department of Insurance may be contacted at the following address and telephone number:

Texas Department of Insurance
333 Guadalupe Street
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439

If you are not fully satisfied with the decision of Cigna's internal appeal review you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant’s rights to any other benefits under the plan.

There is no charge for you to initiate an external review. Cigna and your benefit plan will abide by the decision of the IRO.

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include:

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

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

Relevant Information

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

Legal Action Under Federal Law

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. If your Complaint is expedited, there is no need to complete the Complaint Appeal process prior to bringing legal action.

HC-APL296 04-18
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.

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

The term child means a child born to you; a child legally adopted by you; the child for whom you are the legal guardian; the child who is the subject of a lawsuit for adoption by you; the child who is supported pursuant to a court order imposed on you (including a qualified medical child support order), or your grandchild who is your Dependent for federal income tax purposes at the time of application.

HC-DFS913 11-16
ET

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

CERTIFICATE RIDER – Utah Residents

Rider Eligibility: Each Employee who is located in Utah

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

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

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

HC-ETUTRDR

When You Have A Complaint Or An Appeal

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

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

Start With Customer Service

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

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

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

Appeals Procedure

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

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

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

Level-One Appeal

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

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

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

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

Level Two Appeal

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

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

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

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

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

Independent Review Procedure

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

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

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

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

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by Cigna's Physician reviewer, the review shall be completed within three days.

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

Appeal to the State of Utah

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

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

Notice of Benefit Determination on Appeal

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

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

Relevant Information

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

Legal Action

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

HC-APL135 01-11
V1-ET

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

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

Prescription Drug Benefits

Limitations

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.

If your treating health care provider submits a request for a step therapy exception determination, the request must state the circumstance that qualifies for a step therapy exception.

We will respond to the exception request with our decision within three (3) business days of receipt of the exception request.

In cases where emergency circumstances exist, we will respond with our decision within 24 hours of receipt of an exception request.

If we grant an exception request, we will authorize coverage for the Prescription Drug Product.

You may request an appeal of any step therapy exception denial by following the appeals process.

HC-PHR527 01-21
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. The remainder of any waiting period which existed prior to interruption of coverage may still be applied.

HC-TRM127 11-17
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

Discrimination is Against the Law

Cigna complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at:

https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status

or by phone at 1.800.562.6900, 1.360.586.0241 (TDD).

Complaint forms are available at:

https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx

HC-NOT127 01-21
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Health Care Benefit Manager

A health care benefit manager (“HCBM”) is any person or entity that provides services to or acts on behalf of a health

carrier or employee benefits program. HCBMs directly or indirectly impact the determination or use of benefits for or patient access to health care services, drugs and supplies.

HCBMs include, but are not limited to, specialized benefit types such as pharmacy, radiology, laboratory and mental health. The services of an HCBM also include: Prior authorization or preauthorization of benefits or care, certification of benefits or care, medical necessity determinations, utilization review, benefit determinations, claims processing and repricing for services and procedures, outcome management, provider credentialing and re-credentialing, payment or authorization of payment to providers and facilities for services or procedures, dispute resolution, grievances or appeals relating to determinations or utilization of benefits, provider network management and disease management.

A current list of HCBMs for your plan is available at www.cigna.com/product-disclosures.

HC-NOT128 01-21
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 31days, you must elect Dependent Medical Insurance for your newborn child within the 60 day enrollment period which begins on the first day of birth. If Dependent Medical Insurance is not elected within the 60 day enrollment period, you may be required to wait until the next plan enrollment period to enroll the child for coverage under the plan. Coverage shall include, but not be limited to, coverage for congenital anomalies of such infant children from the moment of birth.

HC-ELG305 01-20
ET

Prescription Drug Benefits

Limitations

Prescription Topical Ophthalmic Products

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

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

Medication Synchronization and Emergency Fills Medication

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

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

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

Upon your request, the prescribing provider or pharmacist shall:

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

Emergency fill refers to a limited dispensed amount of medication that allows time for the processing of a prior authorization request. If you or your Dependent request an

emergency fill, the authorized amount of the emergency fill will be no more than the prescribed amount up to a seven day supply or the minimum packaging size available at the time the emergency fill is dispensed.

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

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

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

Prior Authorization Requirements

If a prior authorization request is approved, your Physician will receive confirmation within forty-eight hours for an urgent care review, and within 5 calendar days for a non-urgent care review. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drug Products. The length of the authorization will depend on the diagnosis and Prescription Drug Products. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Products has been approved, you can contact the Pharmacy to fill the covered Prescription Order or Refill.

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

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

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

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

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

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

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

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

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

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

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

Drug Substitution

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

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

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

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

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

HC-PHR539 01-21
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Payment of Benefits

Medical

Recovery of Overpayment

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

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

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

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

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

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

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

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

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

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

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When You Have a Complaint or an Appeal

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

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

You can start the appeals process at any time.

You are entitled, upon written request, to seek an immediate expedited external review simultaneously, during an initial request and/or the appeal process when the appeal involves concurrent inpatient stays or ongoing outpatient services.

Start with Customer Service

We are here to listen and help. If you have a Grievance, you can call our toll-free number found on your Benefit Identification card or in the "Important Notices" section of this certificate and explain your concern to one of our Customer Service representatives.

A Grievance is a written complaint submitted by or on behalf of an insured person regarding service delivery issues other than denial of payment for medical services or non-provision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

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

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions involving Adverse Determinations and Non-certification. An Adverse Determination or Non-certification coverage decision is a decision by Cigna to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits including the admission to or continued stay in a facility. It also includes a rescission of coverage.

To initiate an appeal for most claims, you must submit a request for an appeal within one year of receipt of a denial notice.

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

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

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable to or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, the "Important Notices" section of this certificate, explanation of benefits or claim form. We will acknowledge in writing, within seventy-two hours, that we have received your request.

Level One Appeal

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

For level one appeals, we will respond in writing with a decision within 14 calendar days after we receive an appeal for a required pre service or Concurrent Care Coverage Determination (decision). We will respond within 14 calendar days after we receive an appeal for a post service coverage determination. If more time or information is needed to make the determination, we will notify you in writing, in this case, the decision will be made within 30 days. For appeals based on experimental treatment exclusions, the decision will be made within 20 days. Any extension beyond 20 days will require your informed written consent.

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

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

Your treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

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

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

For required pre service and Concurrent Care Coverage Determinations, Cigna's review will be completed within 14 calendar days. For post service claims, Cigna's review will be completed within 14 calendar days.

We may request additional information if needed to complete the review. If more time or information is needed to make the determination, we will notify you in writing. Any extension will not delay the decision beyond 30 days without your informed written consent. In the case of appeals based on experimental treatment exclusions, your informed written consent is needed for any extension beyond 20 days. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

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

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non authorization of an admission or continuing inpatient Hospital stay. Your treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing no later than 72 hours after the date of the decision.

Experimental and Investigational Therapies Appeals

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.

Independent Review Procedure

If you are not fully satisfied with the decision of Cigna's internal appeals process regarding your issue or if Cigna has exceeded the timelines without good cause and without reaching a decision, you may request that your appeal be referred to an Independent Review Organization. You may also request that your appeal be referred to an Independent Review Organization if Cigna does not handle your Level One or Level Two Appeal within the timeframe described for the Level One or Level Two Appeal. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

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

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level two appeal review denial. Within one day of selecting the IRO, Cigna will notify you of the name of the Independent Review Organization and its contact information.

Cigna will then forward the file to the Independent Review Organization. Cigna will provide to the Independent Review Organization, no later than the 3rd business day after the date Cigna receives a request for review, all relevant clinical review criteria used by Cigna and other relevant medical, scientific, and cost-effectiveness evidence, the attending or ordering provider's recommendations, and a copy of the terms and conditions of coverage under the relevant health plan.

Cigna will also make available to you and to any provider acting on your behalf, all materials provided to the Independent Review Organization.

When you request an appeal and the dispute involves Cigna's decision to modify, reduce or terminate an otherwise covered health service that you are receiving at the time request is submitted, and Cigna's decision is based upon a finding that the health service, or level of health services is no longer medically necessary or appropriate, Cigna will continue to provide the health care service at your request until a determination is made. If the determination affirms Cigna's decision, you may be responsible for the cost of the continued health service.

The Independent Review Organization will render an opinion not later than the earlier of the 15th day after the date The Independent Review Organization receives the information necessary to make a determination, or the 20th day after the date The Independent Review Organization receives the request that the determination be made. In exceptional circumstances, when The Independent Review Organization has not obtained the necessary information, a determination may be made by the 25th day after The Independent Review Organization received the request for determination. In cases of a condition that could seriously jeopardize a participant's health or ability to regain maximum function, a decision will be rendered not later than the earlier of: 72 hours after The Independent Review Organization receives necessary information, or the 8th day after The Independent Review Organization receives the request for determination.

If the treating Physician determines that a delay could jeopardize the covered person's health or ability to regain maximum function, Cigna will presume the need for expedited review, and treat the review request as such.

Contacting the State of Washington

You have the right to contact the Office of the Insurance Commissioner for assistance at any time. The U.S. Department of Health and Human Services has designated the Washington State Office of the Insurance Commissioner's Consumer Protection Division as the current health insurance consumer assistance office or ombudsman.

You have the right to contact the Office of the Insurance Commissioner for assistance at any time. The Commissioner may be contacted at the following telephone number:

Washington State Office of the Insurance Commissioner
Consumer Protection Division
OIC Consumer Assistance Hotline 1-800-562-6900

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (6) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and (7) information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process. A final notice of an adverse determination will include a discussion of the decision.

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

Relevant Information

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

Legal Action

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

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.

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Dependent

Dependents are:

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

    Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. The plan may require proof not more frequently than annually after the two year period following the child's attainment of the limiting age.

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

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

Anyone who is eligible as an Employee will not be considered as a Dependent or Dependent spouse unless the Dependent or Dependent spouse declines Employee coverage. 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.

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Domestic Partner

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

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Related Supplies

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

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

CERTIFICATE RIDER – Wisconsin Residents

Rider Eligibility: Each Employee who is located in Wisconsin

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

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

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

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When You Have A Complaint Or An Appeal

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

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

Start with Member Services

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

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

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

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

Appeals Procedure

Cigna has a one step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. However, if Cigna reduces or terminates coverage (except where the reduction or termination is due to a plan amendment or termination) for an ongoing course of treatment that Cigna previously approved, and the reduction or termination in coverage will occur before the end of the period of time or number of treatments that Cigna approved, then to initiate an appeal you must submit a request for an appeal of that reduction or termination in coverage within 30 days of receipt of the denial notice. If you appeal timely a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

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

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

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

We will acknowledge in writing that we have received your request and schedule a Committee review. A written notification, including the time and place of the meeting, will be sent to you at least seven calendar days before the meeting. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

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

Assistance from the State of Wisconsin

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

Office of the Commissioner of Insurance
121 West Wilson Street
Madison, WI 53702
608-266-0103 (In Madison)
800-236-8517 (Outside Madison)

Notice of Benefit Determination on Appeal

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

Necessity, experimental treatment or other similar exclusion or limit.

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

Relevant Information

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the appeal process.