Loudoun County School Board

EXTRATERRITORIAL LEGISLATION
Employer Group Waiver Plan (EGWP)

EFFECTIVE DATE: January 1, 2018

ETEGWP18A
3320020

This document printed in December, 2017 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: Loudoun County School Board
Rider Eligibility: Each Employee as noted within this certificate rider
Policy No. or Nos.: 3320020
Effective Date: January 1, 2018

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 Virginia:

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

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

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

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

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

Anna Krishtul

Anna Krishtul, Corporate Secretary

HC-ETRDR

When You Have a Complaint or an Appeal

Start with Customer Service

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

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

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

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

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

HC-APL277 10-16
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Colorado Residents

Rider Eligibility: Each Employee who is located in Colorado

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

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

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

HC-ETCORDR

Definitions

Dependent

Dependents include:

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

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V2-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 30 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-DFS239 04-10
V1-ET

Employer

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

HC-DFS240 04-10
V1-ET

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

CERTIFICATE RIDER – 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.

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Definitions

Dependent

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

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

HC-DFS915 10-16

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

CERTIFICATE RIDER – Delaware Residents

Rider Eligibility: Each Employee who is located in Delaware

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

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

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

HC-ETDERDR

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 – 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.

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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 a written agreement with the Policyholder to make the required contribution, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

HC-ELG9 04-10
V1-ET1

Definitions

Dependent – For Medical Insurance

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

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

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

CERTIFICATE RIDER – Georgia Residents

Rider Eligibility: Each Employee who is located in Georgia

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

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

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

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

HC-ETGARDR

When You Have A Complaint Or An Appeal

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

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

Start With Customer Service

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

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

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

Appeals Procedure

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

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

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

Level-One Appeal

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

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

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

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

Level Two Appeal

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

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 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 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 com-pleted 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.

Appeal to the State of Georgia

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

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

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

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

CERTIFICATE RIDER – Idaho Residents

Rider Eligibility: Each Employee who is located in Idaho

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 Idaho group insurance plans covering insureds located in Idaho. 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 you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Customer Service

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

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

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

Appeals Procedure

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

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

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

Level One Appeal

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

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

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

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 who was 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, the review will be completed within 15 calendar days. For post-service claims, the review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed 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 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.

Your Right To An Independent External Review

Please read this notice carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with your health plan. If you request an independent external review of your claim, the decision made by the independent reviewer will be binding and final on the health carrier. Except in limited circumstances, you will have no further right to have further review of your claim reviewed by a court, arbitrator, mediator or other dispute resolution entity only if your plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as more fully explained below under "Binding Nature of the External Review Decision."

If we issue a final adverse benefit determination of your request to provide or pay for a health care service or supply, you may have the right to have our decision reviewed by health care professionals who have no association with us. You have this right only if our denial decision involved:

- The Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of your health care service or supply, or
- Our determination your health care service or supply was investigational.

You must first exhaust our internal grievance and appeal process. Exhaustion of that process includes completing all levels of appeal, or unless you requested or agreed to a delay, our failure to respond to a standard appeal within 35 days in writing or to an urgent appeal within three (3) business days of the date you filed your appeal. We may also agree to waive the exhaustion requirement for an external review request. You may file for an internal urgent appeal with us and for an expedited external review with the Idaho Department of Insurance at the same time if your request qualifies as an "urgent care request" defined below.

You may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St., 3rd Floor
Boise, Idaho 83720-0043

For more information and for an external review request form:

- See the department's website at: http://www.doi.idaho.gov, or

- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

You may represent yourself in your request or you may name another person, including your treating health care provider, to act as your authorized representative for your request. If you want someone else to represent you, you must include a signed "Appointment of an Authorized Representative" form with your request.

Your written external review request to the Department of Insurance must include a completed form authorizing the release of any of your medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without your completed authorization form.

If your request qualifies for external review, our final adverse benefit determination will be reviewed by an independent review organization selected by the department. We will pay the costs of the review.

Standard External Review Request: You must file your written external review request with the department within four months after the date we issue a final notice of denial.

- Within seven (7) days after the department receives your request, the department will send a copy to us.
- Within 14 days after we receive your request from the department, we will review your request for eligibility. Within five business days after we complete that review, we will notify you and the department in writing if your request is eligible or what additional information is needed. If we deny your eligibility for review, you may appeal that determination to the department.
- If your request is eligible for review, the department will assign an independent review organization to your review within seven days of receipt of our notice. The department will also notify you in writing.
- Within seven (7) days of the date you receive the department's notice of assignment to an independent review organization, you may submit any additional information in writing to the independent review organization that you want the organization to consider in its review.
- The independent review organization must provide written notice of its decision to you, to us and to the department within 42 days after receipt of an external review request.

Expedited External Review Request: You may file a written "urgent care request" with the department for an expedited external review of a pre-service or concurrent service denial. You may file for an internal urgent appeal with us and for an expedited external review with the department at the same time.

Urgent care request means a claim relating to 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 a facility, or any pre-service or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function;
- In the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the disputed care or treatment; or
- The treatment would be significantly less effective if not promptly initiated.

The department will send your request to us. We will determine, no later than the second full business day, if your request is eligible for review. We will notify you and the department no later than one (1) business day after our decision if your request is eligible. If we deny your eligibility for review, you may appeal that determination to the department.

If your request is eligible for review, the department will assign an independent review organization to your review upon receipt of our notice. The department will also notify you. The independent review organization must provide notice of its decision to you, to us and to the department within 72 hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within 48 hours of notice of its decision. If the decision reverses our denial, we will notify you and the department of the approval of coverage (and our intent to pay the covered benefit) as soon as reasonably practicable but not later than one (1) business day after making the determination receiving notice of the decision.

Binding Nature of the External Review Decision: If your plan is subject to federal ERISA laws (generally, any plan offered through an employer to its employees), the external review decision by the independent review organization will be final and binding on us. You may have additional review rights provided under federal ERISA laws.

If your plan is not subject to ERISA requirements, the external review decision by the independent review organization will be final and binding on both you and us. **This means that if you elect to request external review, you will be bound by the decision of the independent review organization. You will not have any further opportunity for review of our denial after the independent review organization issues its final decision.** If you choose not to use the external review

process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

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. However, no action will be brought at all unless brought within three 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.

HC-APL234 1-15
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Indiana Residents

Rider Eligibility: Each Employee who is located in Indiana

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

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

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

HC-ETINRDR

Prescription Drug Benefits

Limitations

Prescription Eye Drops

Refill of prescription eye drops will be allowed when:

- for a 30 day supply, a request for a refill not earlier than 25 days after the date the prescription eye drops were last dispensed;

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

HC-PHR200 10-16
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

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 may also initiate an appeal when Cigna has not made and provided written notice of an initial utilization review determination within allowable time frames. 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.

Internal Appeals

You, an authorized person, or a provider, acting on your behalf, may request an internal appeal if you are dissatisfied with the initial Medical Necessity or clinical appropriateness decision or a coverage denial decision, or we have failed to make and communicate in writing an initial Medical Necessity or clinical appropriateness determination within allowable time frames.

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.

Coverage Denial Appeals

Your appeal of a Coverage Denial determination for which a service, treatment, prescription drug, or device is specifically limited, excluded or denied under the plan will be reviewed and the decision made by someone not involved in the initial decision and not a subordinate of previous decision makers. Provide all relevant documentation with your appeal request.

For required preservice and concurrent care coverage determinations, Cigna’s review will be completed within 30 calendar days of the receipt of your appeal request. For

postservice claims, Cigna’s review will be completed within 30 calendar days.

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. Notification of the appeal review decision will be provided to you and any designated representative and provider(s) acting on your behalf.

Medical Necessity Appeals

Your appeal of Cigna's adverse determination, decision to deny, reduce or terminate a medical service based on a determination that it is not Medically Necessary or is experimental or investigational, will be considered by a Physician, or upon your request, by a reviewer, in the same or similar specialty as the care under consideration, who was not involved in the initial decision as determined by Cigna's Physician Reviewer.

For required preservice and concurrent care coverage determinations, Cigna’s review will be completed within 30 calendar days of the receipt of your appeal request. For postservice claims, Cigna’s review will be completed within 30 calendar days.

You will be notified in writing of the decision to uphold or reverse the decision of the Physician Reviewer within five working days after the decision is made, and within the review time frames above. Notification of the appeal review decision will be provided to you and any designated representative and provider(s) acting on your behalf.

Expedited Internal Appeals

An expedited appeal will be provided when you are hospitalized or as requested when the treating provider is of the opinion that review under a standard time frame could, in the absence of immediate medical attention, result in any of the effects listed in the following paragraph.

You may request that the appeal process be expedited for an appeal of a Medical Necessity Adverse Determination or an appeal of a Coverage Denial if: (a) the time frames under this process would seriously jeopardize your life or health, or with respect to a pregnant woman, the life or health of the unborn child; or the ability to regain maximum function; or result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part; 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.

When an appeal is expedited, we will respond orally with a decision within 72 hours of receipt of the appeal request, followed up in writing within three working days.

Reconsideration of an Internal Review Medical Necessity or Clinical Appropriateness Appeal Decision

You may present new clinical information regarding an adverse internal review appeal determination decision prior to the initiation of the external review process conducted by an Independent Review Entity in the process described in the following paragraph entitled, "External Review by an Independent Review Entity." If you do, Cigna will provide written notice of a reconsideration decision within five working days of receiving additional information related to the request for reconsideration. If a reconsideration is requested, the four months time frame for requesting an external review by an Independent Review Entity shall not begin until Cigna provides the reconsideration decision. If we do not provide a written reconsideration decision within the allowable time frame, then you may request an external review by an Independent Review Entity. Notification of the reconsideration of the appeal review decision will be provided to you and any designated representative or provider(s) acting on your behalf.

External Review by an Independent Review Entity

If you are not fully satisfied with the decision of Cigna's internal appeal decision or reconsideration decision regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Entity (IRE).

Your appeal of Cigna's adverse determination, decision to deny, reduce or terminate a medical service based on a determination that it is not Medically Necessary or is experimental or investigational, will be considered by a Physician or upon your request, by a reviewer, in the same or similar specialty as the care under consideration, who was not involved in the initial decision as determined by Cigna's Physician Reviewer. The Independent Review Entities that Kentucky Department of Insurance assigns in rotation to requests for external independent review are: certified by the Kentucky Department of Insurance, and 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 of any other benefits under the plan.

An IRE will provide an expedited review of an external appeal when requested, and any of the following apply: the treating Physician believes that independent review under a standard time frame would seriously jeopardize your life or health, or with respect to a pregnant woman, the life or health of the unborn child; or the ability to regain maximum function; or result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part; or 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 will pay the cost of the review of an Independent Review Entity, however, there is a $25 filing fee for you to initiate this independent review process, and you will be billed for this directly by the IRE. The IRE will waive the fee if financial hardship can be demonstrated and will refund the fee if their review results in a decision favorable for you. Cigna will abide by the decision of the IRE, and will provide notice to the Kentucky Department of Insurance of its implementation of the decision within 30 days of the IRE's decision in your favor. Cigna will provide coverage of the treatment, service, drug or device as required by the binding decision of the IRE, if you are currently enrolled for coverage by Cigna or you have disenrolled. If you have disenrolled, Cigna will only provide the treatment, service, drug, or device for a period of 30 days.

Call the toll-free number on your Benefit Identification card or contact the appeals representative indicated on your appeal decision notification letter for information about how to request an external review appeal by an IRE.

In order to request a referral to an IRE the following conditions apply: you must submit your request in writing to Cigna, within 60 days of the date of this letter (except that requests for expedited appeals may be requested verbally, followed up by an abbreviated written request). However, when a reconsideration of this decision is requested due to the submission of new clinical information, the 60-day time frame limit for requesting an external review by an IRE will not begin until Cigna has provided a reconsideration decision; you provide a signed copy of the medical release form which provides permission for the IRE to obtain all of the necessary medical records in order to complete its review; you were insured at time of service, or when you or your provider requested the service you have exhausted the Cigna internal review process and received an adverse decision regarding your request involving a Medical Necessity issue; or Cigna has not completed its review of your internal review appeal within the required 30 days; or the Kentucky Department of Insurance has provided notice that Cigna's Coverage Denial determination is not valid because the requested service or coverage is available under the plan. If you believe that you are entitled to an IRE review and Cigna has denied your request for an IRE review, you may file a complaint with the Kentucky Department of Insurance, which shall issue a decision within five days of the receipt of your complaint. If the Department agrees that you are entitled to an IRE review, it shall require Cigna to provide one, as noted above.

If both Cigna and you agree to waive the internal appeal requirement, you may also request that your eligible issue be referred directly to an IRE without initiating or exhausting the internal appeals process.

Cigna will not provide an external review by an IRE if the request for review of the adverse determination has previously gone through the external review process and the IRE found in favor of Cigna and no new clinical information has been submitted since the IRE found in favor of Cigna.

Cigna will forward your request and the file to the IRE, after the Department of Insurance assigns an IRE to your review request.

If you believe that you are entitled to an IRE review and Cigna has denied your request for an IRE review, you may file a complaint with the Kentucky Department of Insurance, which shall issue a decision within five days of the receipt of your complaint. If the Department agrees that you are entitled to an IRE review, it shall require Cigna to provide one, as noted above.

The IRE will render an opinion within 21 calendar days, unless you and Cigna agree to an extension of up to 14 calendar days more. When requested, and when your provider believes that review under a standard time frame would be detrimental to your medical condition, Cigna shall forward your request for an IRE review to the IRE within 24 hours of receiving it, and the IRE will make a decision within 24 hours of receipt of all information required from Cigna. If you agree to a 24-hour extension for the expedited review, then the IRE will provide an expedited decision of the review request within 48 hours of receiving it from Cigna.

The external review process shall be confidential.

External Review of a Coverage Denial by the Kentucky Department of Insurance

You have the right to ask the Kentucky Department of Insurance to review a Coverage Denial determination that has been made following an internal appeal. A Coverage Denial means a determination that a service, treatment, prescription drug or device is specifically limited or excluded under the Plan. You, or an authorized person or provider on your behalf, may submit a written request for review of a Coverage Denial to the Kentucky Department of Insurance at the following address:

Kentucky Department of Insurance
Attn: Coverage Denial Coordinator
P.O. Box 517
Frankfort, KY 40602-0517

Include a copy of the initial Cigna denial notice and the appeal notice with your written request for review of a Coverage Denial. Upon Cigna's receipt of the Kentucky Department of Insurance's (DOI's) determination decision of your Coverage Denial review request, Cigna will: provide the disputed coverage if the DOI has concluded that the treatment, service, drug or device is not specifically limited or excluded by the plan or offer you the opportunity to seek an external review by an Independent Review Entity; or not provide the disputed coverage if the DOI has concluded that the treatment, service, drug or device is not specifically limited or excluded by the

Plan. When Cigna provides the coverage because the DOI has determined the treatment, service, drug or device is not specifically limited or excluded by the plan, it will provide coverage if you are currently enrolled for coverage by Cigna or you have disenrolled. If you have disenrolled, Cigna will only provide coverage for the treatment, service, drug, or device for a period of 30 days.

Appeal to the State of Kentucky

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

Kentucky Department of Insurance
P.O. Box 517
Frankfort, KY 40602-0517
1-800-595-6053
Hearing Impaired: 1-800-462-2081

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; 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; date of the review decision; name and title of the person making the review decision and for Medical Necessity determinations, the name, state of licensure, medical license number and the title of the person making the determination and, as applicable to managed care plans, the signature of a Kentucky-licensed Medical Director; a description of alternative benefits, supplies or services covered by the plan; instructions for requesting an external review by either an IRE or the Kentucky Department of Insurance, as applicable, including applicable time frames and instructions to complete any required forms and whether the request for review of the appeal decision must be in writing; for Medical Necessity appeal determinations, a release of medical records form for provision to the IRE; the name and phone number of a contact person who can provide information about a Coverage Denial determination or about external review by an IRE, as applicable; and for Coverage Denial appeal notices, instructions to include a copy of the initial Coverage Denial notice and the Coverage Denial notice with the written request to the Department of Insurance to conduct a review of a Coverage Denial appeal determination; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process.

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 Internal Review Appeal process.

HC-APL109 05-14
V3-ET1

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

Termination of Insurance

Continuation

Continuation of Medical Insurance during Active Military Duty

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

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

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

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

Reinstatement of Medical Insurance

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

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

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

HC-TRM81 04-10
V1-ET1

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

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, 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 20 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, after 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 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 20 working 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.

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

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

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 20 working days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level-two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the Committee's decision within 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 within two working days of the oral response.

Independent Review Procedure

You also have the right to appeal an unfavorable decision, including denials based on experimental or pre-existing conditions, by way of the State of Maine's independent review process. Your request must be in writing and sent to the State of Maine, Bureau of Insurance, 34 State House Station, Augusta, ME 04330. A request for an independent review must be submitted within 12 months of the date that you receive an adverse determination (decision) under Cigna's complaint and appeals process. When you request an independent review from the Maine's Bureau of Insurance, you may submit additional information for consideration. You may attend the review in person, by telephone, by teleconference or other appropriate electronic means, ask questions of the representatives and have outside assistance.

The Independent Review Organization will issue a written decision within 30 days of receipt of a completed review from Maine's Bureau of Insurance.

You may request an expedited independent review of your appeal prior to exhausting all levels of Cigna's appeals procedure if: Cigna has failed to make a decision on a complaint or an appeal within the time period required; you and Cigna mutually agreed to bypass the appeals procedure; 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 the patient has died.

You may call Cigna at the toll-free telephone number on your ID card for assistance in filing a request for an independent review with the Maine's Bureau of Insurance. There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Review Organization. The Independent Review Program is a voluntary program arranged by Cigna.

You may also call Maine's Bureau of Insurance at 1-800-300-5000 for assistance.

Appeal to the State of Maine

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

State of Maine
Maine Bureau of Insurance
Superintendent of Insurance
34 State House Station
Augusta, ME 04333
1-800-300-5000

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-APL56 04-10
V1-ET

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

CERTIFICATE RIDER – Massachusetts Residents

Rider Eligibility: Each Employee who is located in Massachusetts

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

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

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

HC-ETMARDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

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

HC-ELG12 04-10
V1-ET

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

Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

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

Prescription Drug Benefits

Exclusions

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

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

CERTIFICATE RIDER – 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

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

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

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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, including if you are not in Active Service on that date due to your health status.

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

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

HC-ETNMRDR

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
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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

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

Definitions

Dependent

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

HC-DFS700 07-14
V1-ET

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

CERTIFICATE RIDER – Ohio Residents

Rider Eligibility: Each Employee who is located in Ohio

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

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

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

HC-ETOHRDR

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.

When You Have A Complaint Or An Appeal

Definitions

"Adverse benefit determination" means a decision by a health plan issuer:

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

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

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

"Covered person" means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "Covered person" does include the covered person's authorized representative with regard to an internal appeal or external review.

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

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

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

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

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

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

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

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

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

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

"Superintendent" means the superintendent of insurance.

When You Have a Complaint

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

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

Start With Customer Service

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

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

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

Internal Appeals Procedure

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

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

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

Level One Appeal

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

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

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

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

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

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

Level Two Appeal

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

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

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

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

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

Understanding the External Review Process

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

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

Opportunity for External Review

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

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

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

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

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

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

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

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

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

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

Request for External Review

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

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

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

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

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

IRO Assignment

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

IRO Review and Decision

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

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

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

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

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

Binding Nature of External Review Decision

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

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

If You Have Questions About Your Rights or Need Assistance

You may contact Cigna:

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

1-800-Cigna24

www.Cigna.com

You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215

800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

Contact ODI Consumer Affairs:

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

File a Consumer Complaint:

http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Notice of Benefit Determination on Appeal

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

Relevant Information

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

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

Legal Action

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

HC-APL66
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Definitions

Dependent

Dependents are:

- any child of yours who is:
  - less than 26 years old.
  - you natural child, stepchild, or adopted child;
  - after having reach the limiting age, has been continuously covered under any health plan, and not eligible for coverage under the Medicaid or Medicare program.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

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

It also includes a stepchild who lives with you.

HC-DFS828 10-16
ET

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

CERTIFICATE RIDER – Oregon Residents

Rider Eligibility: Each Employee who is located in Oregon

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

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

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

HC-ETORRDR

Eligibility – Effective Date

Exception to Late Entrant Definition

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

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

An adopted child, or a child placed for adoption before age 19 will not be subject to any Pre-existing Condition limitation if such child was covered within 30 days of adoption or placement for adoption. Such waiver will not apply if 63 days

elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

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

Pre-Existing Condition Limitation for Late Entrant

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

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

For plans which do not standardly include a Pre-existing Condition limitation and which do not include an annual open enrollment period, a Pre-existing condition limitation of 12 months will apply for a Late Entrant.

HC-ELG5 04-10
V1-ET

Definitions

Dependent

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

HC-DFS74 04-10
V1-ET1

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

CERTIFICATE RIDER – Pennsylvania Residents

Rider Eligibility: Each Employee who is located in Pennsylvania

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

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

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

HC-ETPARDR

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

Definitions

Dependent

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

HC-DFS273 04-10
V1-ET

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

CERTIFICATE RIDER – Texas Residents

Rider Eligibility: Each Employee who is located in Texas

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

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

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

HC-ETTXRDR

Prescription Drug Benefits

Covered Expenses

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

HC-PHR213 10-16
ET

Your Payments

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

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

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

HC-PHR138 10-16
ET

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 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, 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 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 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

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. In most instances, you may not initiate a legal action against Cigna until you have completed the Complaint or Adverse Determination Appeal process. If your Complaint is expedited, there is no need to complete the Complaint Appeal process prior to bringing legal action.

Definitions

Dependent

Dependents include:

- any child of yours who is:
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

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

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

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 – Vermont Residents

Rider Eligibility: Each Employee who is located in Vermont

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

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

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

HC-ETVTRDR

Important Notices

Vermont Mandatory Civil Unions Endorsement for Health Insurance

Purpose:

Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons. This endorsement is part of and amends this policy, contract or certificate to comply with Vermont law.

Definitions, Terms, Conditions and Provisions

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

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as “marriage,” “spouse,” “husband,”

"wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a civil union established according to Vermont law.

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

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

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

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

Caution: Federal Rights May or May Not Be Available

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

HC-IMP26 04-10

V4-ET

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 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.

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 are welcome to 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.

You must pay for services given by a Participating Provider or non-Participating Provider if your claim is denied.

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

Prescription Drug Benefit Management Disclosure

Cigna will allow an exception to a benefit management requirement described in this certificate that applies to coverage for Prescription Drugs and Related Supplies, and will provide coverage on the same basis as Cigna would have for the benefit management requirement, if your Physician certifies, based on relevant clinical information about you and sound medical or scientific evidence or the known characteristics of the drug, that the benefit management requirement:

- has been ineffective, or is reasonably expected to be ineffective or significantly less effective in treating your condition, such that an exception is Medically Necessary; or
- has caused you, or is reasonably expected to cause you, adverse or harmful reactions.

To request an exception, your Physician should contact:

Cigna Pharmacy Management
Attn: Pharmacy Services Center
P.O. Box 29030
Phoenix, AZ 85038-9030
Tel. (800) 244-6224

Cigna will accept the Physician's advance certification telephonically, when the Physician designates the situation to be an emergency. Cigna has the right to require the certification to be later confirmed in writing.

A denial of a request for an exception to a benefit management requirement is a determination subject to independent external review under Vermont law. In this situation, the terms of the "External Review Procedure For Non-Mental Health/Substance Abuse Issues" provision, and the "Notice of Benefit Determination on Appeal" provision, both contained in this section of your certificate, apply.

If you or your Dependent have a grievance relating to Cigna's pharmaceutical benefit management program, you should refer to the following "Appeals Procedure" provisions. These provisions also apply to initiating this type of grievance.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions.

While a level one appeal is a required part of the process, a level two appeal is completely voluntary. For example, if a level one appeal is not resolved to your satisfaction, you may choose to make an external appeal to an Independent Panel of Mental Health Care Providers or to an Independent Review Organization, as described later in this provision, rather than pursuing Cigna's voluntary level two appeal process.

The voluntary level two appeal review will be done without deference to the initial adverse benefit determination or to the adverse determination of a level one appeal.

The appeal review takes into account all comments, documents, records, and other information relating to the appeal that you submit, regardless of whether that information was submitted or considered: in the initial benefit determination (for a level one or a voluntary level two appeal); or during the level one appeal (for a voluntary level two appeal). Additional assistance is also available from the Vermont Department of Financial Regulation (DFR), as described later in this provision.

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, including any written comments, documents, records and other information relating to your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Reasonable accommodations will be made to help a person with a disability participate in the appeal process. Additionally, if English is not your primary language, we will provide you with information about how to file an appeal and how to participate in the appeal process, in your primary language, upon your request. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form. We will document the appeal for you and provide copies of that documentation to you, or to your representative.

For any appeal related to an adverse benefit determination, should a reversal of that decision be made during any step of the appeal process, Cigna will promptly authorize or otherwise arrange for coverage of a covered service that was denied or restricted. Neither you nor your treating provider will be liable for any services provided before notification to you of the adverse benefit determination and the final outcome of any appeal or independent external review. However, if your

treating provider or his or her designee refuse or repeatedly fail to communicate with us, when the opportunity to communicate with us has been offered in a time and manner convenient to them, your treating provider will be liable for any services provided to you. You will not be liable in either case.

You must pay for services given by a Participating Provider or a non-Participating Provider in the event of a final denial of your claim.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. This person will also not be the subordinate of any individual who was involved with the initial decision or other issue that is the subject of the appeal. Appeals involving an adverse benefit determination that is based in whole or in part on a medical judgment will be considered by a health care professional who is a clinical peer of your treating provider.

You may request that we identify to you any clinical expert whose advice we obtained in connection with your adverse benefit determination, regardless of whether or not that expert's advice was relied on when the determination was made. Any clinical expert we ask to consult with us regarding your level one appeal will not be the same clinical expert (if any) we consulted with regarding the adverse benefit determination that is the subject of your appeal, or the subordinate of that clinical expert (if any).

A Cigna medical director or his or her designee will offer to directly communicate with your treating provider, or your treating provider's designee, before the appeal is decided.

You will have reasonable access to, and may obtain copies of, all documents, records and other information relevant to your appeal upon request and free of charge, within two business days. In the case of a concurrent or urgent preservice review, you will have access to or may obtain the materials immediately upon request.

Level One Urgent, Preservice Appeal

For an urgent preservice level one appeal, we will orally notify you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 72 hours after we receive the appeal. We will send written confirmation of the determination to you and your treating provider (if known), within 24 hours of our oral notification to you.

Mental health/substance abuse and pharmacy benefit requests are generally considered urgent under Vermont regulatory requirements.

Level One Non-Urgent, Preservice Appeal

For a non-urgent preservice level one appeal, we will send written confirmation to you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 30 calendar days after we receive the appeal.

Level One Concurrent Review Appeal

For a level one appeal related to a request to continue or extend a course of treatment (i.e. a concurrent review), we will orally notify you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 24 hours after we receive the appeal. We will send written confirmation of the determination to you and your treating provider (if known), within 24 hours of our oral notification to you.

Level One Post-Service Appeal

For a level one post-service appeal, we will send written confirmation to you and your treating provider (if known) of our determination within a reasonable time period, but in no case later than 60 calendar days after we receive the appeal.

Level One Appeal Not Related to an Adverse Benefit Determination

For a level one appeal not related to an adverse benefit determination, we will send written confirmation to you within 60 calendar days after we receive the appeal.

Voluntary Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a voluntary second review. To start a voluntary level two appeal, follow the same process required for a level one appeal. If you decide to pursue a voluntary second level appeal review, that decision has no effect on your right to any other benefits under this plan.

The voluntary level two appeal review will be done without deference to the initial adverse benefit determination or to the adverse determination of a level one appeal.

Neither you nor your provider acting on your behalf are responsible for any fees or costs associated with a voluntary level two appeal, should you choose to pursue one.

You will have reasonable access to, and may obtain copies of, all documents, records and other information relevant to your appeal upon request and free of charge, within two business days. In the case of a concurrent or urgent preservice review, you will have access to or may obtain the materials immediately upon request.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone who is a member of the Committee may not: have been involved in the initial adverse benefit determination or other issue that is the subject of the appeal; have been involved in the adverse determination of the level one appeal; or be the subordinate of any person involved with the initial determination or other issue that is the subject of the appeal. 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 request that we identify to you any clinical expert whose advice we obtained in connection with your adverse benefit determination, regardless of whether or not that expert's advice was relied on when the determination was made. Any clinical expert we ask to consult with us regarding your voluntary level two appeal will not be the same clinical expert (if any) we consulted with regarding the adverse benefit determination that is the subject of your appeal, or the subordinate of that clinical expert (if any).

For a voluntary level two appeal we will acknowledge in writing that we have received your request and schedule a Committee review. You will be consulted regarding setting the meeting date for a voluntary second level appeal review. You may present your situation to the Committee in person or by conference call; however, participating in person or via telephone is not a requirement for the voluntary second level appeal meeting to proceed.

Voluntary Level Two Urgent, Preservice Appeal

For an urgent preservice voluntary level two appeal, we will orally notify you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 72 hours after we receive the appeal. We will send written confirmation of the determination to you and your treating provider (if known), within 24 hours of our oral notification to you.

Mental health/substance abuse and pharmacy benefit requests are generally considered urgent under Vermont regulatory requirements.

Voluntary Level Two Non-Urgent, Preservice Appeal

For a non-urgent preservice voluntary level two appeal, we will send written confirmation to you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 30 calendar days after we receive the appeal.

Voluntary Level Two Concurrent Review Appeal

For a voluntary level two appeal related to a request to continue or extend a course of treatment (i.e. a concurrent review), we will orally notify you and your treating provider (if known) of our determination as soon as is possible based on your medical condition, but in no case later than 24 hours after we receive the appeal. We will send written confirmation of the determination to you and your treating provider (if known), within 24 hours of our oral notification to you.

Voluntary Level Two Post-Service Appeal

For a voluntary level two post-service appeal, we will send written confirmation to you and your treating provider (if known) of our determination within a reasonable time period, but in no case later than 60 calendar days after we receive the appeal.

Voluntary Level Two Appeal Not Related to an Adverse Benefit Determination

For a voluntary level two appeal not related to an adverse benefit determination, we will send written notification to you within 60 calendar days after we receive the appeal.

External Review Procedure For Mental Health/Substance Abuse Issues

If you are dissatisfied with either a Level One Appeal decision or a voluntary Level Two Appeal decision, you may request an External Review of your issue by an Independent Panel of Mental Health Care Providers (IP). To start the External Review by an IP, you, your mental health care provider or your representative on your

behalf, must file a written request with Cigna and the IP. You must include your consent for Cigna to release confidential patient files to the IP. The IP address is:

Independent Panel of Mental Health Care Providers
Vermont Department of Financial Regulation (DFR)
89 Main Street
Montpelier, VT 05620-3601
800-631-7788(toll-free) or 802-282-2900

When Cigna receives your request for an External Review, Cigna will send the file supporting the initial decision and the appeal decision(s) to the IP within: 24 hours of receiving the request in emergency situations; and within five working days of receiving the request in all other situations.

The IP may address inquiries to any of the parties (you, your mental health care provider or your authorized representative, or Cigna) and may set a reasonable time period for a response. If Cigna does not provide all necessary information in the required time periods, the delay will result in a presumption in your favor and will not delay the IP's review of the issue. The IP also has the authority to request any or all of the parties to meet with the IP. The IP will make its review decision within 24 hours of receiving all necessary information in emergency situations; and within 15 working days in all other situations. The IP will send its decision by mail or facsimile to Cigna and to the person who filed the request for External Review. Emergency decisions will be communicated by telephone, facsimile or delivered by express mail as appropriate. Cigna is required to abide by the IP's decision. If you have a complaint about a matter that is not related to Medical Necessity or clinical appropriateness, you may file a consumer complaint with the Insurance Consumer Services Division at the following address:

Insurance Consumer Services Division
Vermont Department of Financial Regulation (DFR)
89 Main Street, Drawer 20
Montpelier, VT 05620-3101
802.828.3302

External Review Procedure For Non-Mental Health/Substance Abuse Issues

If you are dissatisfied with a level one appeal or a voluntary level two appeal decision, you may request an External Review of your issue by an Independent Review Organization (IRO).

You (or your authorized representative or your provider on your behalf) may file a written request for External Review within 90 days from the date you receive Cigna's final, written appeal decision. External Appeals for non-Mental Health/Substance Abuse issues may be requested for the following reasons:

- The health care service is a covered benefit that Cigna has determined to be not Medically Necessary.
- A limitation is placed on the selection of a health care provider that you claimed to be inconsistent with limits imposed by this plan and any applicable laws and regulations.
- The health care treatment has been determined to be experimental or investigational or an off-label use of a drug.
- The health care service involves a medically-based decision that a condition is preexisting.

The written request for External Review must be filed with the DFR at the following address:

External Appeals Program
Vermont Department of Financial Regulation (DFR)
89 Main Street, Montpelier, VT 05620-3601
Telephone: 800-631-7788 (toll-free) or 802-828-2900

The insured must file on a form provided by the DFR and include the $25 fee or a request for a waiver or reduction of the fee, for the general release of medical records relevant to the appeal, identification of insurer and a copy of the denial level from the relevant level of appeal. An oral request will also be accepted if made within the 90-day period provided that the request is confirmed in writing on the state request form within 10 calendar days. The External Appeal program is a voluntary program.

Once notified by the DFR that the External Appeal has been accepted for review by an IRO, Cigna must submit all information relevant to the appeal, including: the review criteria used in making the decision; copies of any applicable policies or procedures; and copies of all medical records considered in making the decision in the appeal process. Cigna may request an extension of up to 10 days to submit information and documentation, granted by the DFR for good cause.

Cigna must pay the costs of the External Appeal to the DFR within 30 days of notification of the reasonable and necessary costs of the review by the IRO.

The DFR will provide the request form for an External Appeal. An oral request will also be accepted if made within the 90-day period provided that the request is confirmed in writing on the state request form within 10 calendar days. Within five working days of receiving the External Appeal request the DFR will process the form and materials, and accept the appeal for review by an IRO after determining: that you are or were insured; the service is a covered service under the plan; the External Appeal involves an appealable decision; you have exhausted the internal process; and all information has been provided.

The DFR will notify you when the External Appeal submission is complete, and whether the External Appeal has been accepted for review by an IRO. Cigna must submit any required documentation within 10 calendar days from the date Cigna receives the request notice. Cigna may request a 10-calendar day extension for good cause. You may have an extension for any reason.

The DFR shall provide copies of documentation (and follow-up information) to you and to Cigna; each will have three working days to file responsive documentation with the DFR.

The DFR will assign the External Appeal on a rotating basis to an IRO for clinical review.

The DFR will review the determination of the IRO and then issue the determination to you and to Cigna, which will be binding on Cigna but not on you.

The IRO will conduct a full review, and may request any additional information from you, Cigna, or the DFR. The IRO will complete the review, and forward its written determination to the DFR within five calendar days from receipt if the External Appeal involves emergency or urgently needed care; and 30 calendar days from receipt for all other External Appeal requests. The IRO's written determination will include the clinical rationale for the determination. The IRO may request an extension from the Commissioner.

Additional Assistance

You have the right to contact the Health Insurance Consumer Services unit within the DFR for assistance at any time. This unit can help you if you need general information about health insurance, have concerns about our activities, or are not satisfied with how we resolved your complaint. The DFR may be contacted at the following address and telephone number:

Health Insurance Consumer Services Division
Vermont Department of Financial Regulation (DFR)
89 Main Street, Montpelier, VT 05620-3101
800-631-7788 (toll-free) or 802-828-2900

The Office of Health Care Ombudsman's telephone hotline service can also provide help to Vermonters who have problems or questions about health care and health insurance. Contact them at:

Office of Health Care Ombudsman
264 North Winooski Avenue
Burlington, VT 05402
Telephone: 888-917-7787 or 802-863-2316
TTY: 888-884-1955 or 802-863-2473

Applies to All Issues

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); and upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse 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; 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-APL38 04-10
V2-ET

Definitions

Medically Necessary/Medical Necessity

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

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

HC-DFS155 04-10
V1-ET

Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

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

CERTIFICATE RIDER

No. CR7MNASO41-2

Policyholder: Loudoun County School Board

Rider Eligibility: Each Employee who resides in Massachusetts

Policy No. or Nos. 3320020-EGWPA

EFFECTIVE DATE: January 1, 2018

You will become insured on the date you become eligible if you are in Active Service on that date or if you are not in Active Service on that date due to your health status. If you are not insured for the benefits described in your certificate on that date, the effective date of this certificate rider will be the date you become insured.

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

Anna Krishtul

Anna Krishtul, Corporate Secretary

HC-RDR1 04-10
V1

The pages in your certificate coded **HC-MANCR3** and **HC-MANCR4V3** are replaced by the pages coded **HC-MANCR3** and **HC-MANCR4V5** attached to this certificate rider.

Notice To Massachusetts Residents

This Prescription Drug Benefits health plan, alone, **does not meet Minimum Creditable Coverage standards** and **will not satisfy** the individual mandate that you have health insurance. For additional information, please see the section "Massachusetts Requirement to Purchase Health Insurance," immediately preceding the Schedule.

This plan is not intended to provide comprehensive health care coverage as it covers only **Pharmacy coverage** and **does not meet** Minimum Creditable Coverage standards. However, this plan in conjunction with other medical coverage may help satisfy the Minimum Creditable Coverage standards. Please contact your employer or other plan sponsor to determine the Minimum Creditable Coverage status of the other health plan options offered to you.

HC-MANCR3

Massachusetts Requirement To Purchase Health Insurance:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This Prescription Drug Benefits health plan is not intended to provide comprehensive health care coverage and **does not meet** Minimum Creditable Coverage standards, even if it does include services that are not available in the insured's other health plans.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2018. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

HC-MANCR4V5