

# **Shelby County Government**

EXTRATERRITORIAL LEGISLATION

**EFFECTIVE DATE: January 1, 2015**

ETALLM15A  
3209876

This document printed in February, 2015 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.



# Table of Contents

IMPORTANT INFORMATION.....	4
CERTIFICATE RIDER – Arkansas Residents .....	5
CERTIFICATE RIDER – Delaware Residents .....	6
CERTIFICATE RIDER – Florida Residents.....	9
CERTIFICATE RIDER – Georgia Residents .....	12
CERTIFICATE RIDER – Kansas Residents.....	14
CERTIFICATE RIDER – Kentucky Residents.....	15
CERTIFICATE RIDER – Louisiana Residents.....	19
CERTIFICATE RIDER – Maryland Residents.....	21
CERTIFICATE RIDER – Minnesota Residents .....	23
CERTIFICATE RIDER – Missouri Residents .....	25
CERTIFICATE RIDER – Nebraska Residents .....	27
CERTIFICATE RIDER – North Carolina Residents .....	28
CERTIFICATE RIDER – Oregon Residents .....	29
CERTIFICATE RIDER – South Carolina Residents .....	34
CERTIFICATE RIDER – Texas Residents.....	34
CERTIFICATE RIDER – Virginia Residents .....	43
CERTIFICATE RIDER – Wyoming Residents .....	43

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

**CERTIFICATE RIDER**

Policyholder: Shelby County Government  
Rider Eligibility: Each Employee as noted within this certificate rider  
Policy No. or Nos.: 3209876  
Effective Date: January 1, 2015

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

**IMPORTANT INFORMATION**

**For Residents of States other than the State of Tennessee:**

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

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

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

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

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

  
*Anna Krishtul, Corporate Secretary*

HC-ETDRD



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

**CERTIFICATE RIDER – Arkansas Residents**

Rider Eligibility: Each Employee who is located in Arkansas

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

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

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

HC-ETARRDR

**Eligibility – Effective Date**

**Dependent Insurance**

**Exception for Adopted Children**

Any Dependent child adopted by you while you are insured will become insured from the date the adopted child is placed with you, or from the date you file the petition for adoption, if you elect Dependent Insurance no later than 90 days from the date of the petition for adoption, or from the date of placement, whichever is later. A newborn adopted child will become insured from the moment of birth, if the petition is filed and if you elect Dependent Insurance no later than 90 days from the child’s birth.

If you do not elect to insure your adopted child within such 90 days, or if your petition for adoption is dismissed or denied, no benefits for expenses incurred beyond the 31<sup>st</sup> day following placement or filing of the petition to adopt, whichever is later, will be payable.

HC-ELG1

04-10  
V18-ET2

**Covered Expenses**

- charges made for anesthesia, hospitalization services and/or ambulatory surgical facility charges performed in connection with dental procedures when such services are required to effectively perform the procedures and the patient is:
  - under seven years of age and it is determined by two dentists that treatment in a hospital or ambulatory surgical center is required without delay due to a significantly complex dental condition;
  - a person with a serious diagnosed mental or physical condition; or
  - a person with a significant behavioral problem as determined by their physician.

- charges for colorectal cancer examinations and laboratory tests for covered persons who are fifty years of age or older; less than fifty years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on January 1, 2005; or are experiencing the following symptoms of colorectal cancer as determined by a physician: bleeding from the rectum or blood in the stool; or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five days.

The colorectal screening shall involve an examination of the entire colon, including the following examinations and laboratory tests:

- an annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five years;
- a double-contrast barium enema every five years; or
- a colonoscopy every ten years; and any additional medically recognized screening tests for colorectal cancer required by the Director of the Department of Health, as determined in consultation with appropriate health care organizations.
- charges for prostate cancer examinations and laboratory tests once a year for non-symptomatic covered persons who are forty years of age or older in accordance with the National Comprehensive Cancer Guidelines.

The following applies only to state employees and public school employees:

- charges for diagnosis and treatment of autism spectrum disorder, as defined in the most recent edition of the “Diagnostic and Statistical Manual of Mental Disorders”.

The following treatment is covered when Medically Necessary and evidence-based:

- applied behavior analysis;

- pharmacy care;
- psychiatric care;
- psychological care;
- therapeutic care;
- equipment determined necessary to provide evidence-based treatment;
- any care determined to be Medically Necessary and evidence-based.

In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below for a Dependent child who is age 18 or less, for charges made for Child Preventive Care Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

- a history;
  - physical examination;
  - development assessment;
  - anticipatory guidance;
  - appropriate immunizations, which are not subject to any copay, coinsurance, deductible, or dollar limit; and
  - laboratory tests;
- excluding any charges for:
- more than one visit to one provider for Child Preventive Care Services at each of the Approximate Age Intervals up to a total of 20 visits for each Dependent child;
  - services for which benefits are otherwise provided under this Comprehensive Medical Benefits section;
  - services for which benefits are not payable according to the Expenses Not Covered section.

Approximate Age Intervals are: Birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years.

- charges made for corrective surgery and related medical care for Covered Persons of any age diagnosed as having a craniofacial anomaly if the surgery and treatment are Medically Necessary to improve a functional impairment, as determined by a nationally accredited cleft-craniofacial team. Medical care coverage includes dental care, vision care, and the use of at least one hearing aid. Craniofacial anomaly means a congenital or acquired musculoskeletal disorder that primarily affects the cranial facial tissue.

HC-COV145

04-10  
V3-ET2

## Definitions

### Dependent

The term child means a child born to you or a child legally adopted by you from the date you file a petition for adoption.

HC-DFSS61

01-11  
VI-ET

## 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

## Covered Expenses

- charges made for treatment of Serious Mental Illness. Such Covered Expenses will be payable the same as for other illnesses. Any Mental Illness Maximums in the Schedule and any Full Payment Area exceptions for mental illness will not apply to Serious Mental Illness.

HC-COV122

12-13  
V3-ET1

## When You Have A Complaint Or An Appeal

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

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

### Start with Member Services

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

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

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

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

### Appeals Procedure

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

### Level One Appeal

Your appeal will be reviewed and the decision 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 fifteen 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 an additional information needed to complete the review.

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

### Level Two Appeal

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

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

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 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 Independent Review Organization is composed of persons who are not employed by Cigna HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

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

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

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

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

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

### **Appeal to the State of Delaware**

You have the right to appeal a claim denial for medical reasons or to appeal a claim denial for non-medical reasons to the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services which are in addition to, but do not replace, your right to appeal this decision. You can contact the Delaware Insurance Department for information about an appeal or mediation by calling the Consumer Services Division at (302) 674-7310. You may go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the appeal or mediation process. You may also wish to submit a complaint by sending an email to the Delaware Insurance Department at [consumer@deins.state.de.us](mailto:consumer@deins.state.de.us), or by using the complaint form, found at <http://www.delawareinsurance.gov/complaint/complaintform.pdf> and faxing the complaint to (302) 739-6278.

All appeals must be filed within 60 days from the date you receive this notice otherwise this decision will be final.

### **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-APL63

04-10

V1-ET

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

### CERTIFICATE RIDER – Florida Residents

Rider Eligibility: Each Employee who is located in Florida

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

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

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

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

HC-ETFLRDR

## Eligibility – Effective Date

### Dependent Insurance

#### Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction

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

HC-ELG9

04-10

V1-ET

## Covered Expenses

- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: a baseline mammogram for women ages 35 through 39; a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; a mammogram every year for women age 50 and over; and one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician's recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.
- charges made for diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint. Appliances and non-surgical treatment including for orthodontia are not covered.
- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.
- charges for general anesthesia and hospitalization services for dental procedures for an individual who is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.
- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of

whether or not such services are received in a home birth setting.

- charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: have vertebral abnormalities; are receiving long-term glucocorticoid (steroid) therapy; have primary hyperparathyroidism; have a family history of osteoporosis; and/or are estrogen-deficient individuals who are at clinical risk for osteoporosis.
- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be Medically Necessary by the Physician and in consultation with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.
- charges for newborn and infant hearing screening and Medically Necessary follow-up evaluations. When ordered by the treating Physician, a newborn's hearing screening must include auditory brainstem responses or evoked otoacoustic emissions or other appropriate technology approved by the FDA. All screenings shall be conducted by a licensed audiologist, Physician, or supervised individual who has training specific to newborn hearing screening. Newborn means an age range from birth through 29 days. Infant means an age range from 30 days through 12 months.

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

- a history;
  - physical examination;
  - development assessment;
  - anticipatory guidance; and
  - appropriate immunizations and laboratory tests;
- excluding any charges for:
- more than one visit to one provider for Child Preventive Care Services at each of the Approximate Age Intervals, up to a total of 18 visits for each Dependent child;
  - services for which benefits are otherwise provided under this Covered Expenses section;
  - services for which benefits are not payable, according to the Expenses Not Covered section.

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

months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years and 15 years.

HC-COV25

04-10  
VI-ET1

## Medical Conversion Privilege

### For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by Cigna only to a person who:

- resides in a state that requires offering a conversion policy,
- is Entitled to Convert, and
- applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

### Employees Entitled to Convert

You are Entitled to Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased but only if:

- you are not eligible for other individual insurance coverage on a guaranteed issue basis.
- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

If you retire, you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

## Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for other individual insurance coverage on a guaranteed issue basis, is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

## Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

## Converted Policy

If you reside in a state that requires the offering of a conversion policy, the Converted Policy will be one of Cigna's current conversion policy offerings available in the state where you reside, as determined based upon Cigna's rules.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are Entitled to Convert, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The

premium on its effective date will be based on: class of risk and age; and benefits.

During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

HC-CNV28

04-14  
VI-ET

## Medical Benefits Extension Upon Policy Cancellation

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

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date a succeeding carrier agrees to provide coverage without limitation for the disabling condition;
- the date you are no longer Totally Disabled;
- 12 months from the date the policy is canceled; or
- for pregnancy, until delivery.

## Totally Disabled

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

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

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

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or

- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

HC-BEX42

04-11  
ET

## Definitions

### Dependent

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

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

HC-DFS162

07-14  
V2-ET

## **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, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form.

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

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

### Appeals Procedure

Cigna has a two step appeals procedure for coverage decisions. To initiate an appeal, 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.

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.

### **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. 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.

### **Independent Review Procedure**

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

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

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

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

### **Notice of Benefit Determination on Appeal**

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); upon request

and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

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

#### **Relevant Information**

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

#### **Legal Action**

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna in federal court until you have completed the level one and level two Appeal processes. If your Appeal is expedited, there is no need to complete the level two process prior to bringing legal action. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services or within three years after proof of claim is required under the Plan for Out-of-Network services. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services.

#### **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

HC-APL46

05-14

V2-ET

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

### **CERTIFICATE RIDER – Kansas Residents**

Rider Eligibility: Each Employee who is located in Kansas

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

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

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

HC-ETKSRDR

## Covered Expenses

- abortion when a Physician certifies in writing that the pregnancy would endanger the life of the mother, or when the expenses are incurred to treat medical complications due to abortion.

HC-COV103

04-10  
V1-ET2

## 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

## Covered Expenses

- charges for cochlear implants for persons age 2 and over with the diagnosis of profound sensorineural deafness or postlingual deafness in adults. Cochlear implants for children under age 2 will be covered when, upon review, they are determined to be Medically Necessary.
- charges for the diagnosis and treatment of Autism Spectrum Disorders:  
treatment for Autism Spectrum Disorders includes medical care, habilitative or rehabilitative care, pharmacy if covered by the plan, psychiatric care, psychological care, therapeutic care, and applied behavior analysis prescribed or ordered by a licensed health professional.

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

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

- charges for a telehealth consultation provided the treating Physician or other provider facilitating the use of telehealth ensures that: informed consent of the patient or another person with authority to make the health care treatment decision for the patient, is obtained before covered services are provided through telehealth; and that the confidentiality of the patient's medical information and quality of care protocols are maintained. Telehealth means the use of interactive, audio, video or other electronic media to deliver health care. It includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data and medical education.
- charges for the necessary care and treatment of medically diagnosed inherited metabolic diseases. Coverage must include amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases provided that the amino acid products are prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic diseases, and are administered under the direction of a Physician.

HC-COV162

05-12  
V2-ET1

## When You Have A Complaint Or An Appeal

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

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

### Start with Customer Service

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

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

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

### **Appeals Procedure**

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

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

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

You will be notified in writing of the decision 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.

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 internal appeal would be detrimental to your medical condition.

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. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services or within three years after proof of claim is required under the Plan for Out-of-Network services. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services.

HC-APL109

05-14  
V2-ET

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

### CERTIFICATE RIDER – Louisiana Residents

Rider Eligibility: Each Employee who is located in Louisiana

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

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

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

HC-ETLARDR

### Covered Expenses

- charges for electronic imaging/telemedicine health care services, including, but not limited to, diagnostic testing and treatment. The Physician must be physically present with the patient and communicating with a Physician at the

facility receiving the transmission. Payment shall not be less than 75% of the reasonable and customary payment received for an intermediate office visit. These electronic/telemedicine benefits are subject to utilization review requirements.

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

#### **Autism Spectrum Disorder**

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

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

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

## **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.

## 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 26<sup>th</sup> birthday.

HC-DFS427

04-10  
VI-ET1

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

### CERTIFICATE RIDER – Maryland Residents

Rider Eligibility: Each Employee who is located in Maryland

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

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

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

HC-ETMDRDR

## Important Notices

### Qualified Medical Child Support Order (QMCSO)

#### Eligibility for Coverage Under a QMCSO

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

You, your child's noninsuring parent, a state child support enforcement agency or the Maryland Department of Health and Mental Hygiene must notify your Employer and elect

coverage for that child. If you yourself are not already enrolled, you must elect coverage for both yourself and your child. We will enroll both you and your child within 20 business days of our receipt of the QMCSO from your Employer.

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

### Qualified Medical Child Support Order Defined

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

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

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

### Claims

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

### Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or

legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

### Termination of Coverage Under a QMCSO

Coverage required by a QMCSO will continue until we receive written evidence that: the order is no longer in effect; the child is or will be enrolled under a comparable health plan which takes effect not later than the effective date of disenrollment; dependent coverage has been eliminated for all Employees; or you are no longer employed by the Employer, except that if you elect to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage will be provided for the child consistent with the Employer's plan for postemployment health insurance coverage for Dependents.

HC-IMP89

04-10  
V1-ET3

## The Schedule

The Medical Schedule is amended to remove any of the following OB/GYN notes if included:

**Note:** OB/GYN provider is considered a Specialist.

**Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.

**Note:** Well-Woman OB/GYN visits will be considered a Specialist visit.

**Note:** Well-Woman OB/GYN visits will be considered either a PCP or Specialist depending on how the provider contracts with the Insurance Company.

The "**Outpatient Facility Services**" entry in the Medical Schedule is amended to read as follows:

### Outpatient Facility Services

Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room and when provided instead of an inpatient service, when an attending physician's request for an inpatient admission has been denied.

The Medical Schedule is amended to include the following note in the "Delivery – Facility" provision of the "**Maternity Care Services**" section:

**Note:** Benefit levels will be the same as the benefit levels for Inpatient Hospital Facility Services for any other covered Sickness.

The Medical Schedule is amended to include the following provision, covered at "No charge", in the "**Maternity Care Services**" section:

Home Visits, as required by law and as recommended by the Physician

SCHEDMD-ET3

## Covered Expenses

- charges made for an outpatient service provided instead of an inpatient service, when an attending physician's request for an inpatient admission is denied after utilization review has been conducted.
- charges for an objective second opinion, when required by a utilization review program.
- charges made for inpatient hospitalization services for a mother and newborn child for a minimum of: 48 hours on inpatient hospitalization care after an uncomplicated vaginal delivery; and 96 hours of inpatient hospitalization care after an uncomplicated cesarean section. A mother may request a shorter length of stay than that provided if the mother decides, in consultation with her attending provider, that less time is needed for recovery.

If the mother and newborn child have a shorter hospital stay than that provided, coverage is provided for: one home visit scheduled to occur within 24 hours after hospital discharge; and an additional home visit if prescribed by the attending provider. The home visit must: be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child; be provided by a registered nurse with at least one year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and include any services required by the attending provider. Unless you are enrolled in a Health Savings Account or a High Deductible Health Plan, coverage for the home visits described in this section are not subject to any deductible.

If the mother and newborn child remain in the hospital for at least the minimum length of time provided, coverage is provided for a home visit if prescribed by the attending provider. The home visit must: be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child; be provided by a registered nurse with at least one year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and included any services required by the attending provider. Unless you are enrolled in a Health Savings Account or a High Deductible Health Plan, coverage for the home visits described in this section are not subject to any deductible.

Additionally, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn also remain in the hospital, coverage will be provided for additional hospitalization for the newborn for up to four days.

HC-COV27

04-10

VI-ET3

HC-COV211

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

### **CERTIFICATE RIDER – Minnesota Residents**

Rider Eligibility: Each Employee who is located in Minnesota

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

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

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

HC-ETMNRDR

## **Expenses For Which A Third Party May Be Responsible**

This plan does not cover:

- expenses for which another party may be responsible as a result of having caused or contributed to the Injury or Sickness. If you incur a Covered Expense for which, in the opinion of Cigna, another party may be liable, Cigna may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to Cigna the lesser of:
  - The amount actually paid for such Covered Expenses by Cigna; or

- The amount you actually receive from the third party for such Covered Expenses;  
at the time that the third party's liability for medical expenses is determined and satisfied, whether by settlement, judgment, arbitration or award or otherwise.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

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

Cigna will only exercise its claim rights if the amount received by you is specifically identified in the settlement or judgment as amounts paid for medical expenses.

### **Subrogation/Right Of Reimbursement**

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

1. Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
2. Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

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

### **Lien Of The Plan**

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any

attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;

- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

#### **Additional Terms**

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations

hereunder, regardless of how those future medical benefits are incurred.

- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

HC-SUB1

04-10

V3-ET

## **Termination of Insurance and Special Continuation**

### **Reinstatement of Insurance**

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

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

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

HC-TRM70

09-14

V2-ET1



**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

**Missouri First Steps Program**

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

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

**Important Information About Your Medical Plan**

**Direct Access for OB/GYN Services**

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

**Direct Access for Chiropractic Care Services**

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

**Covered Expenses**

- charges made by a Hospital or an Ambulatory Surgical Facility for anesthesia for inpatient Hospital dental procedures for: a child under the age of five; a person with a severe disability; or a person with a behavioral or medical condition that requires hospitalization or general anesthesia when dental care is provided. Cigna may require prior authorization for hospitalization for dental procedures.
- charges for immunizations (including the associated office visit) for children from birth to age 5 will include poliomyelitis, rubella, rubeola, mumps, tetanus, pertussis, diphtheria, hepatitis B, Haemophilus influenzae type b (Hib), and varicella. This includes the office visit in connection with immunizations. There will be no deductible and no copay.
- charges for or in connection with the diagnosis, treatment and appropriate management of osteoporosis for persons with a condition or medical history for which bone mass measurement is Medically Necessary, provided such services are received by a Physician licensed to practice medicine and surgery in Missouri.
- charges for a colorectal examination and laboratory tests for cancer in accordance with current American Cancer Society guidelines for any nonsymptomatic person covered under the Plan.
- charges for a pelvic examination and Pap smear in accordance with current American Cancer Society

guidelines for any nonsymptomatic woman covered under the Plan.

- charges for telehealth (telemedicine) will be covered on the same basis as covered services provided through a face to face consultation or contact with participating provider. Coverage does not include telehealth site origination fees or costs for the provision of telehealth services. Utilization may be utilized to determine the appropriateness of telehealth as a means of delivering a health care service on the same basis as when the same services is delivered in person.
- charges for prostate cancer examinations and laboratory tests for any insured nonsymptomatic male, in accordance with current American Cancer Society guidelines. Men age 50 and older should discuss getting an annual PSA blood test and a digital rectal exam with their Physician. Men who are at risk, which includes African American or men who have a family history of prostate cancer, should consider being tested at a younger age.
- charges made by a Hospital or other facility that provides obstetrical care for inpatient Hospital services will include Covered Expenses for a mother and her newborn child for 48 hours following a vaginal delivery or for 96 hours following a cesarean delivery. A longer stay will be covered if deemed Medically Necessary. The mother may request an earlier discharge if, after consulting with her Physician, it is determined that less time is needed for recovery. If discharged early, at least 2 post discharge visits will be covered, one of which will be a home visit by either a registered nurse with experience in maternal and child health nursing or a Physician. These visits will include, but are not limited to, a physical assessment of the mother and the newborn; parent education; assistance and training in breast and bottle feeding; education and services for complete childhood immunizations; Medically Necessary clinical tests; and the submission of a metabolic specimen to the state laboratory.

#### **Autism Spectrum Disorder and Applied Behavior Analysis**

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

The terms used above are defined as follows:

- **Autism spectrum disorders** means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- **Diagnosis of autism spectrum disorders** means Medically Necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder.
- **Treatment for autism spectrum disorders** means care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed Physician or licensed psychologist, including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician's or licensed psychologist's license, including, but not limited to: psychiatric care; psychological care; habilitative or rehabilitative care, including applied behavior analysis therapy; therapeutic care; and pharmacy care.
- **Autism service provider** means any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri; or any person who is licensed under chapter 337 as a board-certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board-certified behavior analyst.
- **Applied behavior analysis** means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.
- **Habilitative or rehabilitative care** is professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual.
- **Line therapist** means an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.
- **Pharmacy care** means medications used to address symptoms of an autism spectrum disorder prescribed by a licensed Physician, and any health-related services deemed Medically Necessary to determine the need or effectiveness

of the medications, only to the extent that such medications are included in the insured's health benefit plan.

- **Psychiatric care** means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- **Psychological care** means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
- **Therapeutic care** means services provided by licensed speech therapists, occupational therapists, or physical therapists.

## 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 drugs, except contraceptives, but including injectable infertility drugs. However, self-administered injectables on the Prescription Drug List which are used to treat diabetes, acute migraine headaches, anaphylactic reactions, vitamin deficiencies and injectables used for anticoagulation are covered. However, upon prior authorization by Cigna, injectable drugs may be covered subject to the required Copayment or Coinsurance.

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

### CERTIFICATE RIDER – Nebraska Residents

Rider Eligibility: Each Employee who is located in Nebraska

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

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

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

HC-ETNERDR

### Covered Expenses

- charges made for one screening test for hearing loss for a Dependent child from birth through 30 days old.
- charges for the screening, diagnosis, and treatment of autism spectrum disorder in a covered person under age 21.

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

Behavioral health treatment means counseling and treatment programs, including applied behavior analysis, that are: necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and provided by a certified behavior analyst or a licensed Psychologist if the services performed are within the boundaries of the Psychologist's competency. Coverage for behavioral health treatment, including applied behavior analysis, is subject to a maximum benefit of 25 hours per week.

Pharmacy care means a medication that is prescribed by a licensed Physician and any health related service deemed

Medically Necessary to determine the need or effectiveness of the medication.

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

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

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

HC-COV360

01-15  
V1-ET

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

### **CERTIFICATE RIDER – North Carolina Residents**

Rider Eligibility: Each Employee who is located in North Carolina

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

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

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

HC-ETNCRDR

### **Covered Expenses**

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

services connected with surgical therapies (tubal ligations, vasectomies).

- charges made by a Hospital or Ambulatory Surgical Facility for anesthesia and facility charges for services performed in the facility in connection with dental procedures for: Dependent children below age 9; covered persons with serious mental or physical conditions; or covered persons with significant behavioral problems. The treating provider must certify that hospitalization or general anesthesia is required in order to safely and effectively perform the procedure because of the person's age, condition or problem.
- charges made for or in connection with: the treatment of congenital defects and abnormalities, including those charges for your newborn child from the moment of birth; and with the treatment of cleft lip or cleft palate.
- charges for prescription contraceptives and devices approved by the U.S. Food and Drug Administration and charges for the insertion and/or removal of a prescription contraceptive device and any Medically Necessary exam associated with use of the prescription contraceptive device.
- charges made for surgical and nonsurgical care of Temporomandibular Joint Dysfunction (TMJ) excluding appliances and orthodontic treatment.

HC-COV119

04-10  
V2-ET

## **Definitions**

### **Dependent**

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

HC-DFS700

07-14  
V1-ET



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

**CERTIFICATE RIDER – Oregon Residents**

Rider Eligibility: Each Employee who is located in Oregon

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

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

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

HC-ORM-04-11 HC-ORMEPO-04-11

HC-ETORRDR

**Eligibility – Effective Date**

**Exception to Late Entrant Definition**

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

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

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

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

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

**Pre-Existing Condition Limitation for Late Entrant**

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

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

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

HC-ELG5

04-10

VI-ET

**Certification Requirements**

**For You and Your Dependents**

**Pre-Admission Certification/Continued Stay Review for Hospital Confinement**

Any PAC determination will be binding on Cigna for:

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

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

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

HC-PAC4

11-14

V2-ET

## When You Have a Complaint or 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; and "Physician reviewers" are licensed Physicians.

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

### Start with Member Services

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

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

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

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

### Appeals Procedure

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

### Level One Appeal

Your appeal will be reviewed and the decision 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 acknowledge receipt of an appeal within 7 days of its receipt and 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. However, for postservice appeals involving Medical Necessity, we will respond in writing 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 to complete the review.

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

### Level Two Appeal

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

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

For level two appeals we will acknowledge in writing that we have received your request within 7 days of its receipt and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 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. Cigna's Physician reviewer will consult with a Physician reviewer in the same or similar specialty as the care under consideration to make a decision.

When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

### **Independent Review Procedure**

**You have the right to apply for external review by an Independent Review Organization if you are not fully satisfied with the decision of Cigna's level two appeal review regarding your Medical Necessity or clinical appropriateness issue.** 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 agrees to be bound by the Independent Review Organization's decision notwithstanding the definition of Medical Necessity in the plan.**

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial by Cigna must be based on a Medical Necessity determination, issues of clinical appropriateness, or whether a course or plan of treatment that an insured is undergoing is an active course of treatment for the purpose of continuity of care. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for an independent review under this process.

To request a review, you must notify the Appeals Coordinator in writing within 180 days of your receipt of Cigna's level two appeal review denial. You must also sign a waiver granting the Independent Review Organization access to your medical records.

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 a provider with an established clinical relationship to the insured, the review shall be completed within three days.

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

### **Appeal to the State of Oregon**

You have the right to file a complaint or seek other assistance from the Oregon agency. Assistance is available:

- by calling (503) 947-7984 or the toll free message line at (888) 877-4894;
- by writing to the Oregon agency, Consumer Protection Unit, 350 Winter Street NE, Room 440-2, Salem, OR 97301-3883;
- through the Internet at <http://www.cbs.state.or.us/external/ins/>; or
- by e-mail at: [DCBS.INSMAIL@state.or.us](mailto:DCBS.INSMAIL@state.or.us)

### **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; 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 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**

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-APL4

04-10

VI-ET

### **When You Have a Complaint or 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; and "Physician reviewers" are licensed Physicians.

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

### **Start with Member Services**

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

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

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

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

### **Appeals Procedure**

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

#### **Level One Appeal**

Your appeal will be reviewed and the decision 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 acknowledge receipt of an appeal within 7 days of its receipt and 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. However, for postservice appeals involving Medical Necessity, we will respond in writing 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 to complete the review.

You may request that the appeal process be expedited if: the time frames under this process would seriously jeopardize

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

#### **Level Two Appeal**

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

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

For level two appeals we will acknowledge in writing that we have received your request within 7 days of its receipt and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 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. Cigna's Physician reviewer will consult with a Physician reviewer in the same or similar specialty as the care under consideration to make a decision. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

## Independent Review Procedure

**You have the right to apply for external review by an Independent Review Organization if you are not fully satisfied with the decision of Cigna's level two appeal review regarding your Medical Necessity or clinical appropriateness issue.** 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 agrees to be bound by the Independent Review Organization's decision notwithstanding the definition of Medical Necessity in the plan.**

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial by Cigna must be based on a Medical Necessity determination, issues of clinical appropriateness, or whether a course or plan of treatment that an insured is undergoing is an active course of treatment for the purpose of continuity of care. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for an independent review under this process.

To request a review, you must notify the Appeals Coordinator in writing within 180 days of your receipt of Cigna's level two appeal review denial. You must also sign a waiver granting the Independent Review Organization access to your medical records.

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 a provider with an established clinical relationship to the insured, the review shall be completed within three days.

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

### Appeal to the State of Oregon

You have the right to file a complaint or seek other assistance from the Oregon agency. Assistance is available:

- by calling (503) 947-7984 or the toll free message line at (888) 877-4894;
- by writing to the Oregon agency, Consumer Protection Unit, 350 Winter Street NE, Room 440-2, Salem, OR 97301-3883;
- through the Internet at <http://www.cbs.state.or.us/external/ins/>; or
- by e-mail at: [DCBS.INSMAIL@state.or.us](mailto:DCBS.INSMAIL@state.or.us)

### 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; 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 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

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-APL4

04-10

VI-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 – 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-ETTDRDR

## **Important Notice**

### **Notice of Coverage for Acquired Brain Injury**

Your health benefit plan coverage for an acquired brain injury includes the following services:

- cognitive rehabilitation therapy;
- cognitive communication therapy;
- neurocognitive therapy and rehabilitation;
- neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment;
- neurofeedback therapy and remediation;
- post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and
- reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition.

Post-acute care treatment or services may be obtained in any facility where such services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

The following words and terms shall have the following meanings:

**Acquired brain injury** - A neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

**Cognitive communication therapy** - Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

**Cognitive rehabilitation therapy** - Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

**Community reintegration services** - Services that facilitate the continuum of care as an affected individual transitions into the community.

**Enrollee** - A person covered by a health benefit plan.

**Health benefit plan** - As described in the Insurance Code § 1352.001 and § 1352.002.

**Issuer** - Those entities identified in the Insurance Code § 1352.001.

**Neurobehavioral testing** - An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

**Neurobehavioral treatment** - Interventions that focus on behavior and the variables that control behavior.

**Neurocognitive rehabilitation** - Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

**Neurocognitive therapy** - Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

**Neurofeedback therapy** - Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

**Neurophysiological testing** - An evaluation of the functions of the nervous system.

**Neurophysiological treatment** - Interventions that focus on the functions of the nervous system.

**Neuropsychological testing** - The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

**Neuropsychological treatment** - Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

**Other similar coverage** - The medical/surgical benefits provided under a health benefit plan. This term recognizes a distinction between medical/surgical benefits, which encompass benefits for physical illnesses or injuries, as opposed to benefits for mental/behavioral health under a health benefit plan.

**Outpatient day treatment services** - Structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

**Post-acute care treatment services** - Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

**Post-acute transition services** - Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

**Psychophysiological testing** - An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

**Psychophysiological treatment** - Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

**Remediation** - The process(es) of restoring or improving a specific function.

**Services** - The work of testing, treatment, and providing therapies to an individual with an acquired brain injury.

**Therapy** - The scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

## Examinations for Detection of Cervical Cancer

Benefits are provided for each covered female age 18 and over for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Benefits include at a minimum: a conventional Pap smear screening; or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

If any person covered by this plan has questions concerning the above, please call Cigna at 1-800-244-6224, or write us at the address on the back of your ID card.

HC-IMP16

04-10  
V2-ET1

## The Schedule

The following sentence is added to the “Hospital Emergency Room” section under the “Emergency and Urgent Care Services” section of **The Schedule** shown in your medical certificate:

### Emergency and Urgent Care Services

Hospital Emergency Room

(including a properly licensed freestanding emergency medical care facility)

The Schedule is amended to indicate the following:

### Cardiovascular Disease Screening

Charges for Cardiovascular Disease Screenings are payable at 100%, with one screening every 5 years, not to exceed \$200.

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

The **Nutritional Evaluation** annual maximum shown in the Medical Schedule is amended to indicate the following:

“3 visits per person however, the 3 visit limit will not apply to treatment of diabetes.”

SCHEDTX-ET

## Covered Expenses

- charges made for annual mammogram for women 35 years of age and older.
- charges made for reconstructive surgery of craniofacial abnormalities for a child who is younger than 18 years of age to improve the function of, or to attempt to create a normal appearance for an abnormal structure caused by

congenital defects, developmental deformities, trauma, tumors, infection or disease.

- charges made for an acquired brain injury including: cognitive rehabilitation therapy; cognitive communication therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment; neurofeedback therapy and remediation; post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit
- charges made for an annual medically recognized diagnostic examination for the early detection of cervical cancer for each covered female age 18 and over. Such coverage shall include at a minimum: a conventional Pap smear screening; or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.
- charges for a screening test for hearing loss from birth through the date the child is 30 days old, and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. Unless you are enrolled in a Health Savings Account or a High Deductible Health Plan, a deductible will not apply.
- charges for or in connection with a medically recognized screening exam for the detection of colorectal cancer for each insured who is at least 50 years of age and at normal risk for developing colon cancer. Coverage will include: an annual fecal occult blood test; and either a flexible sigmoidoscopy performed every five years; or a colonoscopy performed every 10 years.
- charges for a drug that has been prescribed for the treatment of a covered chronic, disabling or life-threatening Sickness, provided that drug is Food and Drug (FDA) approved for at least one indication and is recognized for treatment in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or supported by articles in accepted, peer-reviewed medical literature. Coverage will also be provided for any medical services necessary to administer the drug.
- charges made for all generally recognized services prescribed in relation to Autism Spectrum Disorder for

Dependent children through age 9. Such coverage must be prescribed by a Physician in a treatment plan and shall include evaluation and assessment services; applied behavior analysis; behavior training and behavior management; speech therapy; occupational therapy; physical therapy; or medications or nutritional supplements used to address symptoms of autism spectrum disorder.

Autism Spectrum Disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder--Not Otherwise Specified. Neurobiological disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

- charges for a service provided through Telemedicine for diagnosis, consultation, treatment, transfer of medical data, and medical education.

These benefits may not be subject to a greater deductible, copayment, or coinsurance than for the same service under this plan provided through a face-to-face consultation.

The term Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and medical education through the use of interactive audio, video, or other electronic media. It does not include the use of telephone or fax.

- charges for Hospital Confinement of a mother and her newborn child for 48 hours following an uncomplicated vaginal delivery, or for 96 hours following an uncomplicated cesarean delivery. After consulting with her attending Physician the mother may request an earlier discharge if it is determined that less time is needed for recovery. If medical necessity requires the mother and/or newborn to remain confined for longer than 48 hours, the additional confinement will be covered. If the mother is discharged prior to the 48 or 96 hours described above, a postpartum home care visit will be covered. Postpartum home care services include parent education; assistance and training in breast feeding and bottle feeding; and the performance of any necessary and appropriate clinical tests.
- charges for diagnostic and surgical treatment for conditions effecting temporomandibular joint and craniomandibular disorders which are a result of: an accident; trauma; a congenital defect; a developmental defect; or a pathology.
- charges made for or in connection with annual diagnostic examinations for the detection of prostate cancer, regardless of medical necessity; and a prostate-specific antigen (PSA) test for a man who is at least 50 years of age and asymptomatic or at least 40 years of age with a family history of prostate cancer, or another prostate risk factor.
- charges for a minimum of 48 hours of inpatient care following a mastectomy and a minimum 24 hours following a lymph node dissection for the treatment of breast cancer.

A shorter period of inpatient care may be deemed acceptable if the insured consults with the Physician and both agree it is appropriate.

- charges for immunizations for children from birth through age 5. These immunizations will include: diphtheria; Haemophilus influenzae type b; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella (chicken pox); rotavirus; and any other children's immunizations required by the State Board of Health. A deductible, copayment, or coinsurance is not required for immunizations.

### **Biologically Based Mental Illness**

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

### **Diabetes**

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

Diabetes Equipment and Supplies:

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

- Prescription and non-prescription medications for controlling blood sugar level;
- Podiatric appliances, including up to two pair of therapeutic footwear per year, for the prevention of complications associated with diabetes;
- Glucagon emergency kits.

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

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

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

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

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

### Clinical Trials

Charges made for routine patient care costs in connection with a phase I, II, III or IV clinical trial if the clinical trial is conducted in relation to the prevention, detection or treatment of a life threatening disease or condition. The clinical trial must be approved by: the Centers for Disease

Control and Prevention of the U.S. Department of Health and Human Services; the National Institutes of Health; the U.S. Food and Drug Administration; the U.S. Department of Defense; the U.S. Department of Veterans Affairs; or an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.

HC-COV416

01-15  
V1-ET3

### Inpatient Mental Health Services

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

Inpatient Mental Health services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

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

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

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

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

HC-COV7

04-10  
V5-ET1

### **Breast Reconstruction and Breast Prostheses**

- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered. Such coverage shall be provided in a manner determined to be appropriate in consultation with the Physician and the insured.

### **Reconstructive Surgery**

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.

HC-COV14

04-10  
v2

## **Termination of Insurance**

### **Special Continuation of Medical Insurance**

If Medical Insurance for you or your Dependent would otherwise cease for any reason except due to involuntary termination for cause or due to discontinuance in entirety of the policy or an insured class, coverage may be continued if:

- the person was covered by this policy and/or a prior policy for the three months immediately prior to the date coverage would otherwise cease, and
- the person elects continuation coverage and pays the first monthly premium within 60 days of the later of either the date coverage would otherwise cease or the date required notice is provided.

Coverage will continue until the earliest of the following:

- 6 months after continuation coverage is elected for plans with COBRA and 9 months after continuation coverage is elected for those without;
- the end of the period for which premium is paid;
- the date the policy is discontinued and not replaced;

- the date the person becomes eligible for Medicare; and
- the date the person becomes insured under another similar policy or becomes eligible for coverage under a group plan or a state or federal plan.

### **Texas – Special Continuation of Dependent Medical Insurance**

If your Dependent's Medical Insurance would otherwise cease because of your death or retirement, or because of divorce or annulment, his insurance will be continued upon payment of required premium, if: he has been insured under the policy, or a previous policy sponsored by your Employer, for at least one year prior to the date the insurance would cease; or he is a Dependent child less than one year old. The insurance will be continued until the earliest of:

- three years from the date the insurance would otherwise have ceased;
- the last day for which the required premium has been paid;
- with respect to any one Dependent, the earlier of the dates that Dependent: becomes eligible for similar group coverage; or no longer qualifies as a Dependent for any reason other than your death or retirement or divorce or annulment; or
- the date the policy cancels.

If, on the day before the Effective Date of the policy, medical insurance was being continued for a Dependent under a group medical policy: sponsored by your Employer; and replaced by the policy, his insurance will be continued for the remaining portion of his period of continuation under the policy, as set forth above.

Your Dependent must provide your Employer with written notice of retirement, death, divorce or annulment within 15 days of such event. Your Employer will, upon receiving notice of the death, retirement, divorce or annulment, notify your Dependent of his right to elect continuation as set forth above. Your Dependent may elect in writing such continuation within 60 days after the date the insurance would otherwise cease, by paying the required premium to your Employer.

HC-TRM27

04-10  
VI-ET

## **Medical Benefits Extension Upon Policy Cancellation**

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury or Sickness, Medical Benefits will be paid for Covered Expenses

incurred in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:

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

### **Totally Disabled**

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

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

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

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

HC-BEX17

04-10  
VI-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.

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

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

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

### **Complaint Appeals Procedure**

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

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

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call us at the toll-free

number on your Benefit Identification card, explanation of benefits or claim form.

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

We will acknowledge in writing that we have received your request within five working days after the date we receive your request for a Committee review and schedule a Committee review. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the complaint appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

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

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

#### **When You have an Adverse Determination Appeal**

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

information supporting your appeal. We will acknowledge the appeal in writing within five working days after we receive the Adverse Determination Appeal request.

Your appeal of an Adverse Determination will be reviewed and the decision made by a health care professional not involved in the initial decision. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

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

You may request that the 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 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.

HC-APL132

04-10  
VI-ET

## **Definitions**

### **Dependent**

Dependents include:

- any child of yours who is:
  - less than 26 years old.

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

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

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

HC-DFS414

04-10  
V5-ET

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

### **CERTIFICATE RIDER – Virginia Residents**

Rider Eligibility: Each Employee who is located in Virginia

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

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

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

HC-ETVARDR

## **Termination of Insurance**

### **Reinstatement of Medical Insurance**

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

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

HC-TRM31

04-10  
V1-ET

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

### **CERTIFICATE RIDER – Wyoming Residents**

Rider Eligibility: Each Employee who is located in Wyoming

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

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

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

HC-ETWYDR

## **Covered Expenses**

- charges for cancer screening tests, including: a pelvic examination, Pap smear and clinical breast cancer examination, including a mammogram; a prostate

examination and laboratory tests; and a colorectal cancer examination and laboratory tests for any nonsymptomatic person.

HC-COV160

04-10  
V1-ET1