Meriden City and Board of Education

GROUP RETIREE MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2022

CN005
3333413

This document printed in August, 2022 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

THIS IS NOT A STANDARDIZED MEDICARE SUPPLEMENT PLAN

HC-IMP75 10-10

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

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: Meriden City and Board of Education

GROUP POLICY(S) — COVERAGE
3333413 - RBP GROUP RETIREE MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2022

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

Jill Stadelman

Jill Stadelman, Corporate Secretary

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Important Notices

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY : اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki

dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese –
注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711را شمارەگیری کنید).

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How to File Your Claim

Upon enrollment, for smoother claim payment, you should provide Cigna with your Medicare Claim Number as it appears on your Medicare I.D. card. You can:

- Enter it at **myCigna.com** or
- Call Cigna Customer Service at the number on the back of your Cigna I.D. card.

You must submit expenses covered by this plan to Medicare before they can be considered for payment under this plan. Hospitals, Skilled Nursing Facilities, home health agencies, and Physicians are required by law to file Medicare claims for covered services and supplies that you receive.

If you visit your doctor or hospital, your doctor or hospital will send a claim directly to Medicare. Medicare will pay their part and will send the claim to Cigna. You will receive a Medicare Summary Notice (MSN) from Medicare. The Summary Notice will list your Medicare claims information including a note if the information was sent to your private insurer (Cigna) for additional benefits.

For services not covered by Medicare but covered by this plan, you will need to send a claim form to Cigna. You may get the required claim forms from your Benefit Plan Administrator, by calling customer service or from our website at www.Cigna.com. All fully completed claim forms and bills should be mailed directly to the claim address that appears on the back of your Cigna ID card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL CIGNA CUSTOMER SERVICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR CIGNA IDENTIFICATION CARD.

  YOUR CIGNA ACCOUNT/GROUP NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR CIGNA IDENTIFICATION CARD.

  PROVIDE YOUR MEDICARE CLAIM IDENTIFICATION NUMBER AS IT APPEARS ON YOUR MEDICARE ID CARD.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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Eligibility - Effective Date

Insurance for Eligible Persons

This plan is offered to you as an Eligible Person. To be insured, you may have to pay part of the cost.

You will become eligible for insurance on the day you are in a Class of Eligible Persons.

Classes of Eligible Persons

Each Eligible Person as reported to the insurance company by your Employer.

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by completing the application process, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election.

Insurance for Dependents

For your Dependents to be insured, you may have to pay part of the cost of Dependent Insurance.

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by completing the application process, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Eligibility Restrictions

The Eligible Person must enroll for coverage under either this plan or a Related Plan in order to enroll for Dependent Insurance.

Group Retiree Medical Benefits (Part A and Part B)

The Schedule

For You and Your Dependents

Part A benefits cover the same benefits covered under Medicare Part A. Part B benefits cover the same benefits covered under Medicare Part B. Unless otherwise noted, the benefits covered under this plan are limited to expenses approved by Medicare but not paid by Medicare. To receive benefits, you and your Dependents must pay a portion of the Covered Expenses. That portion is the Deductible and Coinsurance.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

Deductibles

Deductibles are expenses to be paid by you or your Dependent. Deductible amounts are separate from and are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Part A or Part B expenses for:

- Coinsurance
- Deductible

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100%.

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	PART B EXPENSES PLAN PAYS
Lifetime Maximum Applies to Part A and B expenses	Unlimited	
Coinsurance Levels		
Part A	Coinsurance as shown below of the amount approved by Medicare but not paid by Medicare	Not Applicable
Part B Deductible	Not Applicable	Not Covered
Remainder of expenses after the Part B Deductible	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Calendar Year Deductible (Applies to Part B expenses)		
Individual	$233 per person	

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	PART B EXPENSES PLAN PAYS
Out-of-Pocket Maximum (Applies to Part A and Part B expenses) Individual Family Maximum	Unlimited per person Unlimited per family	
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		
Inpatient Hospital - Facility Services Semi-private room and board, general nursing and miscellaneous services and supplies. **A new benefit period begins each time the member is out of the hospital more than 60 days** Days 1 - 150 per benefit period (using 60 lifetime reserve days)	100% after plan deductible of the amount approved by Medicare but not paid by Medicare	Not Applicable
Once Lifetime Reserve days are used (or would have ended if used) additional 365 days of confinement per person per lifetime Days 1-365	100% after plan deductible of the amount approved by Medicare but not paid by Medicare	Not Applicable
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities First 20 days 21st – 100th day	Medicare pays in full. 100% after plan deductible of the amount approved by Medicare but not paid by Medicare	Not Applicable Not Applicable

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	PART B EXPENSES PLAN PAYS
Hospice/Inpatient Respite Care (includes Bereavement Counseling)	100% after plan deductible of the amount approved by Medicare but not paid by Medicare	Not Applicable
Physician's Services		
Primary Care Physician's Office Visit	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Specialty Care Physician's Office Visit	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Surgery Performed In the Physician's Office	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Second Opinion Consultations (provided on a voluntary basis)	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Allergy Treatment/Injections	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Preventive Care		
Routine Physical age 18 and over (including screenings and coverage for Preventive Breast Ultrasounds). Also covers one time per lifetime "Welcome to Medicare" exam.	Not Applicable	100% of the amount approved by Medicare but not paid by Medicare
Immunizations age 18 and over (includes flu shots, hepatitis B shots and Pneumococcal shots)	Not Applicable	100% of the amount approved by Medicare but not paid by Medicare
Early Cancer Detection Screenings	Not Applicable	100% of the amount approved by Medicare but not paid by Medicare
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room and Treatment Room	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Inpatient Hospital Physician's Visits/Consultations	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	PART B EXPENSES PLAN PAYS
Inpatient Hospital Professional Services Surgeon/Assistant Surgeon Radiologist Pathologist Anesthesiologist	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Outpatient Professional Services Surgeon/Assistant Surgeon Radiologist Pathologist Anesthesiologist	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Emergency and Urgent Care Services		
Physician's Office Visit	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Hospital Emergency Room	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Emergency Room Physician	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Urgent Care Facility or Outpatient Facility	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Independent x-ray and/or Lab Facility in conjunction with an ER visit	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Ambulance	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	PART B EXPENSES PLAN PAYS
Laboratory, Radiology Services and Advanced Radiological Imaging (includes diagnostic tests, pre-admission testing, MRIs, MRAs, CAT Scans and PET Scans)		
Physician's Office	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Outpatient Hospital Facility	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Independent X-ray and/or Lab Facility	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Outpatient Short-Term Rehabilitative Therapy and Chiropractic Care Services Maximum: Unlimited up to Medicare limits Includes: Physical Therapy Speech Therapy Occupational Therapy Chiropractic Therapy (includes Chiropractors) Pulmonary Rehab Cognitive Therapy Cardiac Rehab	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Home Health Care Maximum: Unlimited	Not covered by plan. Medicare pays in full.	100% after plan deductible of the amount approved by Medicare but not paid by Medicare

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	PART B EXPENSES PLAN PAYS
Maternity Care Services		
Initial Visit to Confirm Pregnancy **Note:** OB/GYNs are considered Specialists	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Office Visits in addition to the global maternity fee when performed by an OB/GYN or specialist	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Delivery - Facility		
(Inpatient Hospital)	Same as plan's Inpatient Hospital Facility benefit	Not Applicable
(Birthing Center)	Not Applicable	Same as plan's Outpatient Surgical Facility benefit
Abortion Includes non-elective procedures only		
Physician's Office Visit	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Not Applicable
Outpatient Facility	Not Applicable	Same as plan's Outpatient Facility benefit
Inpatient Physician's Services	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Outpatient Physician's Services	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	PART B EXPENSES PLAN PAYS
Family Planning Services		
Surgical Sterilization Procedure for Vasectomy/Tubal Ligation Limited to Medicare covered services (excludes reversals)		
Physician's Office	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Not Applicable
Outpatient Facility	Not Applicable	Same as plan's Outpatient Facility benefit
Inpatient Physician's Services	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Outpatient Physician's Services	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Infertility Treatment Services Not Covered include: • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant are (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not Applicable	Not Covered

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	PART B EXPENSES PLAN PAYS
Organ Transplants Includes all medically appropriate, non-experimental transplants		
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Not Applicable
Inpatient Physician's Services	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Outpatient Physician's Services	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Travel Services	Not Covered	Not Covered
Durable Medical Equipment Maximum: Unlimited	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
External Prosthetic Appliances Maximum: Unlimited	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Diabetic Supplies and Services	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Wigs Wigs prescribed for hair loss as a result of chemotherapy for cancer	Not Applicable	100% after plan deductible
Clinical Trials		
Physician's Office Visit	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Not Applicable
Outpatient Facility	Not Applicable	Same as plan's Outpatient Facility benefit
Inpatient Physician's Services	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Outpatient Physician's Services	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	PART B EXPENSES PLAN PAYS
Dental Care Limited to Medicare covered dental services		
Physician's Office Visit	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Inpatient Facility	Same as plan's Inpatient Hospital Facility benefit	Not Applicable
Outpatient Surgical Facility	Not Applicable	Same as plan's Outpatient Surgical Facility benefit
Physician's Services	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
TMJ Surgical and Non-surgical	Not Covered	Not Covered
Habilitative Services Maximum: Unlimited	Not Applicable	100% after plan deductible up to the Maximum Reimbursable Charge
Routine Foot Disorders Includes only services associated with foot care for diabetes and peripheral vascular disease.	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Blood First 3 pints in a calendar year	100% of the amount approved by Medicare but not paid by Medicare	100% of the amount approved by Medicare but not paid by Medicare
Additional amounts per calendar year	100% of the amount approved by Medicare but not paid by Medicare	100% of the amount approved by Medicare but not paid by Medicare
Part B Covered Prescription Drugs	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare
Smoking Cessation Counseling	Not Applicable	100% of the amount approved by Medicare but not paid by Medicare
Mental Health and Substance Abuse		
Inpatient	Same as plan's Inpatient Hospital Facility benefit	Not Applicable
Outpatient	Not Applicable	100% after plan deductible of the amount approved by Medicare but not paid by Medicare

BENEFIT HIGHLIGHTS	PART A EXPENSES PLAN PAYS	PART B EXPENSES PLAN PAYS
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA: Calendar Year Deductible: $250 Lifetime Maximum: $50,000	Not Applicable	80% after foreign travel deductible

Group Retiree Medical Benefits

Covered Expenses

The term Covered Expenses means expenses incurred by a person while covered under this plan for the charges listed below for:

- Preventive Care Services , and
- Services or supplies that are Medically Necessary for the care and treatment of an Injury or Sickness, as determined by Medicare or Cigna.

As determined by Cigna, Covered Expenses may also include all charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below. **Any applicable Deductibles or limits are show in The Schedule.**

Covered Expenses

- charges made by a Hospital for Part A Medicare Eligible Expenses for a Hospital Confinement from the first day through the 150th day in any Medicare Benefit Period (includes 60 lifetime reserve days).
- charges made by a Hospital for a Hospital Confinement for an additional 365 days per benefit period per person per lifetime once the lifetime reserve days are used (or would have ended if used).
- charges made by a Skilled Nursing Facility, rehabilitation hospital and sub-acute facilities for Part A Medicare Eligible Expenses from the 21st day through the 100th day in any Medicare Benefit Period. A person must have been in the Hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the Hospital.
- charges made for Hospice/Inpatient Respite Care for Part A Medicare Eligible Expenses which includes bereavement counseling for a terminally ill person.
- charges made for the Medicare Approved Amounts remaining for Part B Medicare Eligible Expenses including but not limited to:
  - charges made for Inpatient and Outpatient Physicians services.
  - charges made for laboratory and radiology services.
  - charges for Medicare Eligible Expenses for preventive care for an annual routine physical and a one time "Welcome to Medicare" exam.
  - charges made for immunizations.
- charges for the following Early Cancer Detection Screenings including but not limited to:
  - pap test and pelvic examination;
  - prostate cancer screening and digital exam;
  - mammogram screening;
  - colonoscopy;
  - sigmoidoscopy;
  - fecal blood test; and
  - barium enema.
- charges made for the first 3 pints of blood in a calendar year or equivalent quantities of packed red blood cells as defined under federal regulations unless replaced in accordance with federal regulations.
- charges made for additional amounts of blood after the first 3 pints in a calendar year.
- charges made for outpatient short-term rehabilitative therapy.
- charges made for home health care services.
- charges made for maternity.
- charges made for family planning surgical related services.
- charges made for durable medical equipment and external prosthetic appliances.
- charges made for diabetic supplies, including but not limited to: blood glucose test strips, blood glucose monitor, lancet devices and lancets, glucose control solutions for checking accuracy of test strips and monitors and therapeutic shoes or inserts.
- charges made for clinical trials.
- charges made in an outpatient facility, emergency room or urgent care facility.
- charges made for ambulance services.
- charges made for routine foot disorders for diabetes and peripheral vascular disease when Medically Necessary.
- charges made for prescription drugs including but not limited to: antigens, osteoporosis drugs, erythropoiesis, blood clotting factors, injectable drugs, immunosuppressive drugs, oral cancer drugs, and oral anti-nausea drugs.
- charges for smoking cessation counseling.
- charges made for mental health and substance abuse.
- charges made for organ transplants.
- charges made for dental care.
- charges for a wig, if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy.
- charges made for any Foreign Travel Emergency Services deductible and for the charges remaining after any such deductible. Covered Expenses will include any Emergency

Services that begin within the first 60 days of travel outside the United States in a year.

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Exclusions

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- any expense that is:
  - not a Medicare Eligible Expense; or
  - beyond the limits imposed by Medicare for such expense; or
  - excluded by name or specific description by Medicare; except as specifically provided under the "Covered Expenses" section or any other portion of this certificate including any riders attached.
- any portion of a Covered Expense to the extent paid or payable by Medicare;
- any benefits payable under one benefit of this plan to the extent payable under another benefit of this plan;
- Covered Expenses incurred after coverage terminates.

In addition, the following exclusions apply to any service that is a Covered Expense under this plan, but is not covered by Medicare:

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- private Hospital rooms and/or private duty nursing.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs (other than as described in Covered Expenses).
- blood administration for the purpose of general improvement in physical condition.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- massage therapy.

General Limitations

- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.

- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- expenses incurred outside the United States other than expenses for medically necessary urgent or emergent care while temporarily traveling abroad.

HC-EXC359 10-19

Payment of Benefits

To Whom Payable

Medical Benefits are assignable to the provider if the provider does not participate with Medicare. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. All claims for providers that participate with Medicare will be assigned to the provider.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Medicare Provider even if benefits have been assigned. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the provider.

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

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

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

Recovery of Overpayment

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

Calculation of Covered Expenses

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

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

HC-POB31 10-10

Termination of Insurance

Eligible Persons

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Persons or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.

Dependents

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

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

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

HC-TRM75 10-10
V1

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

All references in this section to "Employee" shall be deemed to mean "Eligible Person".

HC-FED1 10-10

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, provided the child is otherwise eligible under this plan.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

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.

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.

HC-FED4 10-10

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the adopted children or children who became Dependent children of the Employee due to marriage.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility

for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:

- divorce or legal separation;
- cessation of Dependent status (such as reaching the limiting age);
- death of the Employee;
- termination of employment;
- reduction in work hours to below the minimum required for eligibility;
- you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
- you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
- the other plan no longer offers any benefits to a class of similarly situated individuals.

- **Termination of Employer contributions (excluding continuation coverage).** If a current or former Employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the Employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an Employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the adoption of a Dependent child, coverage will be effective immediately on the date of adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

HC-FED96 04-17

Coverage for Maternity Hospital Stay

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (*e.g.,* your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

HC-FED10 10-10

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

HC-FED12 10-10

Coordination with Medicare

Benefits provided under this plan will not duplicate any benefits paid by Medicare. Determination of the amount payable under this plan will be based upon the difference between the amount paid by Medicare and the Medicare Approved Amount (for Part A) or the Maximum Reimbursable Charge (for Part B).

Eligibility for Medicare

This plan will assume the amount payable under Part A and/or Part B of Medicare for a person who is eligible for but is not currently enrolled in that Part(s), or Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract. A person is considered to be eligible for Medicare on the earliest date any coverage under Medicare could become effective for that person.

HC-FED41 07-12

Claim Determination Procedures

The following complies with federal law. Provisions of applicable laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents as applicable, and in the determination notices.

Preservice Determinations

When you or your representative requests a required prior authorization, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's reviewer, in consultation with the treating health care professional, will decide if an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow Cigna's procedures for requesting a required preservice determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be

provided orally, unless you or your representative requests written notification.

Concurrent Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent coverage determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, (if applicable); 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 claim; 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 in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

HC-FED79 03-13

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- The Employer files Bankruptcy under Title 11 of the United States Code.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;

- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

Clinical Trials

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

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

(b) either

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

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

The clinical trial must meet the following requirements:

The study or investigation must:

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

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

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

Routine patient care costs do not include:

- the investigational drug, device, item, or service, itself; or

- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

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

HC-FED53 10-13

Definitions

Dependent

Dependents are:

- your lawful spouse who is eligible for Medicare; and
- any unmarried child of yours who is eligible for Medicare by reason of disability who is:
  - 18 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you who is eligible for Medicare by reason of disability. It also includes a stepchild who lives with you.

Benefits for a Dependent child will continue until the last day of the calendar month in which the Dependent child is no longer eligible for Medicare by reason of disability.

No one will be considered as a Dependent of more than one Eligible Person.

HC-DFS373 10-10
V2

Eligible Person

The term Eligible Person means a former employee, a retiree or terminated employee of the Employer who is eligible for Medicare by reason of age or disability.

HC-DFS374 10-10
V1

Emergency Services

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

HC-DFS6 04-10
V1

Employer

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFS8 04-10
V1

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

HC-DFS10 04-10
V1

Hospice Care Services

The term Hospice Care Services means any Medicare Eligible Expenses provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a home health care agency, a hospice facility, or any other licensed facility or agency under a hospice care program.

HC-DFS375 10-10
V1

Hospital

The term Hospital means:

- an institution that is approved by Medicare and has agreed to participate in Medicare.
- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance Abuse or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

HC-DFS376 10-10
V1

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is a registered bed patient in a Hospital upon the recommendation of a Physician.

HC-DFS377 10-10
V1

Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

Medically Necessary/Medical Necessity

"Medically necessary" or "medical necessity" means health care services that a physician/dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical/dental practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician/dentist or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For the purposes of this definition, "generally accepted standards of medical/dental practice" means standards that are based on credible scientific evidence published in peer-reviewed medical/dental literature generally recognized by the relevant medical/dental community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

HC-DFS80 04-10
V1

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

HC-DFS17 04-10
V1

Medicare Approved Amount

The term Medicare Approved Amount means the amount in the Original Medicare Plan that a Physician or supplier can be paid, including what Medicare pays and any deductible, coinsurance or copayment that you pay. It may be less than the actual amount charged by a Physician or supplier.

HC-DFS378 10-10
V1

Medicare Eligible Expenses

The term Medicare Eligible Expenses means expenses covered by Medicare to the extent recognized as reasonable by Medicare.

HC-DFS379 10-10
V1

Medicare Part A Benefit Period

The term Medicare Part A Benefit Period means a period of time during which a Medicare beneficiary is Hospital or Skilled Nursing Facility confined. A Medicare Benefit Period:

- begins when a Medicare beneficiary is admitted to a Hospital as an inpatient; and
- ends when he or she has not been Confined in a Hospital or Skilled Nursing Facility for 60 consecutive days.

HC-DFS380 10-10
V1

Medicare Part A Deductible

Medicare Part A Deductible means the deductible amount that you are required to pay under Medicare for expenses incurred at the beginning of a Medicare Part A Benefit Period.

HC-DFS381 10-10
V1

Medicare Part B Deductible

Medicare Part B Deductible means the deductible amount that you are required to pay under Medicare Part B each calendar year for Medicare Eligible Expenses.

HC-DFS382 10-10
V1

Original Medicare Plan

The Original Medicare Plan means a fee-for-service health plan that lets you go to any Physician, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare Approved Amount, and you pay your share (coinsurance). In some cases you may be charged more than the Medicare Approved Amount. The Original Medicare Plan has Part A (Hospital Insurance) and Part B (Medical Insurance).

HC-DFS383 10-10
V1

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

A Physician may be either a Participating Physician or Non-Participating Physician. A Participating Physician is one who has agreed in advance to accept Medicare assignments for claims. The amount the Physician can charge is limited to the Medicare Approved Amount. A non-Participating Physician has not agreed to accept Medicare assignment and may charge more than the Medicare Approved Amount

HC-DFS384 10-10
V1

Related Plan

The term Related Plan means the Policyholder's employee health plan.

HC-DFS385 10-10
V1

Sickness

The term Sickness means a physical illness. This includes mental illness and substance abuse.

HC-DFS386 10-10
V1

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which meets all of the conditions required in order to be eligible for payment as a skilled nursing facility under Medicare.

HC-DFS387 10-10
V1

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

Certificate Rider

You will become insured on the date you become eligible, if you are in a class of Eligible Persons on that date.

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

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

The following is added to your certificate:

The following is added to the medical section of your certificate prior to the **Table of Contents**:

The Policyholder may cancel the Policy as of any Premium Due Date by giving written notice to the Insurance Company before the date. The Policyholder will provide each insured certificate holder with 15 days advance notice prior to the cancellation or discontinuance of the group health insurance plan.

The following is added to the medical section of your certificate entitled **Covered Expenses**:

- charges for a single baseline mammogram for women ages 35 to 39; and mammograms every year for women age 40 and older. Coverage is also provided for:
  - comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology, or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's Physician or advanced practice registered nurse, subject to any plan provisions that apply to other covered services, not to exceed a copay of $20 per ultrasound; and
  - magnetic resonance imaging (MRI) of an entire breast or breasts, in accordance with guidelines established by the American Cancer Society.
- a baseline mammogram, provided by breast tomosynthesis, at the option of the woman covered under the policy, for any woman who is thirty-five to thirty-nine years of age, subject to pre-authorization and medical necessity review.
- a baseline mammogram, provided by breast tomosynthesis, at the option of the woman covered under the policy, every year for any woman who is 40 years of age or older, subject to pre-authorization and medical necessity review.
- charges made for hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies and delivers speech and other sounds at levels equivalent to that of normal speech and conversation. Coverage may be subject to limitations as shown in The Schedule.
- charges for amino acid modified preparations and low protein modified food products prescribed by a Physician for the therapeutic treatment of inherited metabolic diseases. Inherited metabolic disease means: a disease for which newborn screening is required, and cystic fibrosis. Low protein modified food product means a product formulated to have less than one gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease. Amino acid modified preparation means a product intended for the dietary treatment of inherited metabolic diseases under the direction of a Physician.
- charges for a mother and her newborn for at least 48 hours of inpatient care after a vaginal delivery and at least 96 hours of care after a cesarean section. A shorter length of stay is acceptable if the mother consults with her Physician and both agree it is appropriate. If the mother and newborn are discharged earlier than the 48/96 hours, two follow-up visits will be covered if provided by qualified healthcare personnel trained in postpartum maternal and newborn care. The first visit will be within 48 hours of discharge; the second will be within seven days of discharge. Follow-up visits include, but are not limited to: physical assessment of the newborn; parent education; assessment of the home support system; and any Medically Necessary and appropriate clinical tests. Assistance and training in breast and/or bottle feeding will be covered as long as medically necessary. Any stay beyond the 48/96 hours will be covered if deemed Medically Necessary.
- charges for a wig, if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy.
- charges for the surgical removal of tumors and treatment of leukemia, including: outpatient chemotherapy;

reconstructive surgery; cost of any nondental prosthesis, including any maxillofacial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis; and outpatient chemotherapy following surgical procedures in connection with the treatment of tumors.

- charges for laboratory and diagnostic tests for all types of diabetes; Medically Necessary equipment required for treatment; and drugs and supplies prescribed by the Physician.
- charges for Medically Necessary training for treatment of diabetes, to include: up to 10 hours of counseling following initial diagnosis on nutrition and proper use of equipment and supplies; up to 4 hours following diagnosis by a Physician, following change in symptoms, or conditions that warrants change in patient's self-management; up to 4 hours of training and education on new techniques and treatments. An office visit copayment applies.
- charges for neuropsychological testing ordered by a licensed Physician to assess the extent of any cognitive or developmental delays due to chemotherapy or radiation treatment in any eligible Dependent child diagnosed with cancer on or after January 1, 2000.
- charges for colorectal cancer screening including, but not limited to: an annual fecal occult blood test; colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with recommendations established by the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations. Any additional colonoscopy ordered by a Physician in a policy year will be covered without requiring the covered person to pay any additional coinsurance, deductible or other out-of-pocket expense. Any treatment procedure that a Physician initially undertakes as a screening colonoscopy or screening sigmoidoscopy will not be subject to the deductible.
- charges for laboratory and diagnostic tests including prostate-specific antigen (PSA) tests to screen for prostate cancer paid in-network at 100%. In addition, provider coverage of PSA and treatment for men who are symptomatic or whose biological father or brother has been diagnosed with prostate cancer, and all men 50 and older for out-of-network paid same as any other illness.
- charges made for Medically Necessary wound-care supplies for the treatment of epidermolysis bullosa, when administered under the direction of a Physician.
- charges made for contraceptives, other than oral contraceptives. Refer to Participation Drug Benefits section for information regarding coverage of oral contraceptives.
- charges for at least 48 hours of inpatient care following a mastectomy or lymph node dissection. Longer or shorter inpatient care or outpatient surgery must be recommended by the Physician who is treating the patient, after conferring with the patient.

Clinical Trials

- This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:
  - (a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and
  - (b) either:
    - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
    - the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).
- For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- The clinical trial must meet the following requirements:
  - The study or investigation must:
    - be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
    - be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
    - involve a drug trial that is exempt from having such an investigational new drug application.
- Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:
  - services required solely for the provision of the investigational drug, item, device or service;
  - services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
  - services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and

- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

- Routine patient care costs do not include:
  - the investigational drug, item, device, or service, itself; or
  - items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- If your plan includes In-Network providers, Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:
  - there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
  - the clinical trial is conducted outside the individual's state of residence.

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Speech, physical and occupational therapies are covered for autism spectrum disorder.

- charges for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders shall be provided for individuals 18 years of age or younger, if such processes and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association. No coverage shall be provided for cosmetic surgery.
- charges for licensed ambulance service to or from a Hospital.
- coverage for general anesthesia, nursing and related hospital services provided in conjunction with inpatient, outpatient or one-day dental services shall be provided if: the services are deemed Medically Necessary by the treating dentist or oral surgeon and the insured's Primary Care Physician (if election of a Primary Care Physician is required under the plan); and the patient is either:
  - determined by a dentist, in conjunction with a Primary Care Physician (if election of a Primary Care Physician is required under the plan) to have a dental condition that requires procedures performed in a hospital; or
  - a person who has a developmental disability determined by the Primary Care Physician (if election of a Primary Care Physician is required under the plan) to place the person at serious risk.
- charges for pain treatment procedures and medications, including all means Medically Necessary to make a diagnosis and treatment plan. Such procedures or medications must be ordered by a pain management specialist Physician who is credentialed by the American Academy of Pain Management or who is a board certified anesthesiologist, neurologist, physiatrist, oncologist or radiation oncologist with additional training in pain management. Pain means any sensation in which a person experiences severe discomfort, distress or suffering due to provocation of sensory nerves.
- charges for hypodermic needles or syringes prescribed by a practitioner, for the purpose of administering medication for medical conditions, provided that the medications are covered under the plan.
- for treatment of Lyme disease to include 30 days of intravenous antibiotic therapy, 60 days of oral antibiotic therapy, or both. Further treatment will be covered if recommended by a board certified rheumatologist, infectious disease specialist or neurologist.
- charges made for the diagnosis and treatment of autism spectrum disorders, on the same basis as for any other Sickness.
- Medically Necessary appliances and supplies related to an ostomy; colostomy; ileostomy; or urostomy surgery, such as collection devices, irrigation equipment and supplies, skin barriers, and skin protectors.
- charges made for emergency medical care arising from accidental ingestion or consumption of a controlled drug, for at least: 30 days in any calendar year for confinement as an inpatient in a hospital; and $500 per calendar year for expenses incurred outside a hospital.
- charges for human leukocyte antigen testing (also referred to as histocompatibility locus antigen testing) for A, B and DR antigens for use in bone marrow transplantation, for covered persons being tested to be potential transplant donors. Coverage is limited to covered persons who complete and sign an informed consent form at the time of such testing that authorizes the results of the test to be used for participation in the National Marrow Donor Program.
- charges made for gender reassignment surgery (male-to-female or female-to-male) including, when applicable, hormone therapy, orchiectomy, vaginoplasty (including colovaginoplasty, penectomy, labiaplasty, clitoroplasty, vulvoplasty, penile skin inversion, repair of introitus, construction of vagina with graft, coloproctostomy), vaginectomy (including colpectomy, metoidioplasty with initial phalloplasty, urethroplasty, urethromeatoplasty), hysterectomy and salpingo-oophorectomy, as well as initial mastectomy or breast reduction.
- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs, approved surgeries and other therapeutic

procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); low tubal ovum transfer; and the services of an embryologist including but not limited to uterine embryo lavage and embryo transfer.

Services also include ovulation induction for no less than a lifetime maximum benefit of four cycles, and intrauterine insemination up to a lifetime maximum benefit of three cycles.

Coverage for in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and low tubal ovum transfer services is limited to those individuals who are unable to conceive or sustain a successful pregnancy through less expensive and medically viable (as determined by the individual's physician) treatments or procedures covered under the plan, for no less than a combined lifetime maximum benefit of two cycles with not more than two transfers per cycle.

The lifetime maximum benefits above are determined by all treatments provided in a covered person's lifetime while the person has been continuously covered (no break in coverage) under this plan, beginning on the first plan effective date or renewal date on or after October 1, 2005.

Coverage for infertility services is subject to prior authorization. Covered infertility treatment must be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility.

Infertility is defined as:

- the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period.
- the inability of opposite-sex partners to achieve conception after six months of unprotected intercourse.
- the inability of a woman, with or without an opposite-sex partner, to achieve conception after at least six trials of medically supervised artificial insemination over a one-year period; and
- the inability of a woman, with or without an opposite-sex partner, to achieve conception after at least three trials of medically supervised artificial insemination over a six-month period of time.

This benefit includes diagnosis and treatment of both male and female infertility. However, the following are specifically excluded infertility services:

- reversal of male and female voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges and services;
- cryopreservation of sperm and eggs;
- gestational carriers and surrogate parenting arrangements; and
- any experimental, investigational or unproven infertility procedures or therapies.

Home Health Care Services

Home Health Care Services are provided only if Cigna has determined in advance that the home is a medically appropriate setting. Home Health Care Services are: provided under the terms of a Home Healthcare plan for the person named in that plan, and are approved in writing by a Physician within seven days following discharge from a Hospital or Other Health Care Facility. Medical social services are provided to or for the benefit of a covered person. This does not apply to a person who is terminally ill with a life expectancy of 6 months or less. In the case of a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Care Services will be provided only when another family member or care giver is present in the home to meet any need for non-skilled care and/or custodial services.

Home Health Care Services are services that can be provided during home visits by Other Health Professionals. The services of a home health aide are covered when these services are in direct support of skilled health care services provided by Other Health Professionals. A visit is defined as a period of 4 hours or less. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Professionals in providing Home Health Care Services are covered. Medical Social Services are defined as services rendered under the direction of a Physician, by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to:

- assessment of the social, psychological and family problems related to or arising out of the person's illness and treatment;
- appropriate action and utilization of community resources to assist in resolving such problems;
- participation in the development of the overall plan of treatment for the person.

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

services provided in the home are subject to the rules that apply to Short-term Rehabilitative Therapy.

Mental Health and Substance Use Disorder Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes.

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

Inpatient Mental Health Services

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

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

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

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

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment. Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

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

Inpatient Substance Use Disorder Rehabilitation Services

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

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

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

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

Outpatient Substance Use Disorder Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, a group, or a Substance Use Disorder Intensive Outpatient Therapy Program. Covered services include evidence-based maternal, infant and early childhood home visitation services and intensive, family-based and community-based treatment programs. Substance Use Disorder Partial Hospitalization services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in

accordance with the laws of the appropriate legally authorized agency.

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

Substance Use Disorder Detoxification Services

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

Exclusions

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

- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature except for extended day treatment programs as described in Section 17a-22 of the 2016 supplement to the Connecticut general statutes.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care except for extended day treatment programs as described in Section 17a-22 of the 2016 supplement to the Connecticut general statutes.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.
- any unproven or investigational services and supplies, including all related services and supplies. Unproven or investigational services and supplies are medical, surgical, diagnostic, psychiatric, Substance Use Disorder or other health care technologies, treatments, procedures, drugs and biologics or devices that are determined by Cigna to be: not demonstrated by the weight of existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the sickness, condition, injury or illness for which its use is proposed; or not currently the subject of active investigation because prior investigations and/or studies failed to establish proven efficacy and/or safety; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use, except for accepted off-label use of drugs and biologics, consistent with Cigna policy; or substantially confined to use in the research setting; or the subject of review or approval by an Institutional Review Board for the proposed use, except as specifically provided in the "Clinical Trials" benefit section; or the subject of an ongoing phase I, II or III clinical trial, except as specifically provided in the "Clinical Trials" benefit section.
- for or in connection with experimental, investigational or unproven services.

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

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

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

The plan or policy shall not deny coverage or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA

for the use for which the drug or biologic has been prescribed, and is recognized for the treatment of cancer in any one of the following: the U.S. Pharmacopeia Drug Info. Guide for the Health Care Professional; the AMA Drug Evaluations; or the American Society of Health System Pharmacist's American Hospital Formulary Drug Service Information. Peer-reviewed medical literature means a published study in a journal or other publications in which original manuscripts have been critically reviewed for scientific accuracy, validity and reliability by unbiased international experts, and that has been determined by the International Committee of Medical Journal Editors to have met its Uniform Requirements for Manuscripts Submitted to Biomedical Journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or any carrier that delivers, issues for delivery, renews, amends or continues a health insurance policy in this state.

- The plan or policy shall not deny coverage for procedures, treatments or the use of any drug as experimental if such procedure, treatment or drug, for the illness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a phase III clinical trial of the federal Food and Drug Administration.

The following provision is added to your certificate:

Medical Benefits Extension For Total Disability 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 are hospital or facility confined on that date due to an Injury or Sickness covered by the policy, Medical Benefits will be paid for covered professional services, supplies and facility charge expenses incurred in connection with the confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are discharged from the hospital or facility in which you were confined on the policy cancellation date;
- 12 months from the date the policy is canceled;
- the terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when you or your Dependent's Medical Benefits cease.

The following is added to your certificate:

When You Have A Grievance 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. Your health care professional can appeal without designation, for coverage requests required to be initiated by the health care professional and for urgent care coverage requests. "Physician Reviewers" are licensed Physicians depending on the care, treatment or service under review.

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

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, 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 appeals procedures for coverage decisions based on the Medical Necessity of requested services, and coverage decisions based on other criteria. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal timely a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna
National Appeals Organization (NAO)
P.O. Box 188011
Chattanooga, TN 37422

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

If Cigna fails to strictly adhere to all the requirements of the internal claims and appeals process, you may initiate an external Independent Review and/or pursue any available remedies under applicable state or federal law, regardless of whether Cigna asserts that it substantially complied with the requirements, or that any error Cigna committed was de minimis.

Appeals of Medical Necessity Decisions

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by an appropriate clinical peer or peers. A "clinical peer" is a Physician or other health professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and for a mental health review concerning: a child or adolescent Substance Use Disorder or a child adolescent mental disorder, holds a national board certification or a doctoral level psychology degree with training and clinical experience in child and adolescent Substance Use Disorder or child and adolescent mental disorder, as applicable; for an adult Substance Use Disorder or an adult mental disorder, holds a national board certification in psychiatry or a doctoral level psychology degree with training or clinical experience in the treatment of adult Substance Use Disorders or adult mental disorders, as applicable.

For these appeals, we will respond in writing or by electronic means to you or your representative and the provider of record with a decision within 30 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 60 calendar days after we receive an appeal for a postservice coverage determination. These response times apply regardless of whether all of the information necessary to make a decision accompanies your appeal filing.

If Cigna relies on any new or additional evidence or scientific or clinical rationale to make the appeal decision, we will provide you such evidence and rationale free of charge, and sufficiently in advance of issuing a decision to permit you a reasonable opportunity to respond prior to the date our decision is made.

You may request that the appeal process be expedited if: (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay, or health care services after receiving emergency services and not yet discharged from a facility; or (c) you are appealing on the grounds you are a person who has been diagnosed with a condition that creates a life expectancy in that person of less than two years and who has been denied an otherwise covered procedure, treatment or drug on the grounds that it is experimental.

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 Cigna appeal would be detrimental to your medical condition. A request for an expedited appeal made by a health care professional with knowledge of your medical condition shall be deemed an urgent care request.

Cigna's Physician Reviewer, or your Physician, will decide if the expedited appeal criteria apply. When an appeal is expedited, we will respond orally with a decision to you and your representative or provider within the lesser of: 72 hours after the appeal is received or two working days after the required information is received, followed up in writing. For expedited appeals involving any of the following Substance Use Disorder or mental disorders, a decision will be completed and communicated within 24 hours after the appeal is received:

- a Substance Use Disorder, or a co-occurring mental disorder; or
- a mental disorder requiring: inpatient services; partial hospitalization; residential treatment; or intensive outpatient services necessary to keep a covered person from requiring an inpatient setting.

For any concurrent review of an urgent care request, coverage for the treatment shall be continued without additional liability to you until you are notified of the review decision.

Appeals of Coverage Decisions Not Based on Medical Necessity

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

We will notify you not later than three business days after receiving your appeal that you are entitled to submit written material for us to consider when reviewing your appeal.

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 20 business days after we receive the appeal. If more time is needed to make the appeal determination, we will notify you in writing before the determination period ends, to extend the determination period up to 10 additional business days and to specify the reasons for the delay.

Assistance from the State of Connecticut

If you are dissatisfied with the decision of Cigna's appeals review regarding Medical Necessity, clinical appropriateness, health care setting, level of care or effectiveness, or a rescission of coverage or determination of ineligibility for coverage, or any person who has been diagnosed with a condition that creates a life expectancy of less than two years who has been denied an otherwise covered procedure,

treatment or drug on the grounds it is experimental, you, or your provider with your consent, may file a written appeal for review with the State of Connecticut, within 120 days after the determination. The external review program is a voluntary program.

An Appeal made by your provider will be considered to be made on your behalf and with your consent if the admission, service, procedure or extension of stay has not yet been provided or if the determination not to certify creates a financial liability for you. Your provider may file any permitted appeal on your behalf with your written consent.

External appeals must be submitted on a prescribed state form with fee of $25 (with no such fees to exceed $75 for a person within a calendar year), which is refundable to you if the original adverse determination is reversed and which may be waived in cases of financial hardship. Your submission must also include an executed medical release form, an evidence of coverage, and evidence that the internal appeal process was exhausted.

Appeals to the State of Connecticut must be submitted to:

Connecticut Insurance Department
Attn: External Review
P.O. Box 816
Hartford, CT 06142-0816

For overnight delivery only, please mail your application for external review to:

Connecticut Insurance Department
Attn: External Review
153 Market Street, 7th Floor
Hartford, CT 06103

Within one business day after receiving the request, the Connecticut Insurance Department (CID) must send a copy to Cigna. Within five business days after receiving the copy, Cigna must complete a preliminary review of whether the request is complete and eligible for external review, then notify you and the CID within one business day after completing the preliminary review. For an Expedited Appeal to the State as described below, the preliminary review must be complete within one calendar day and notification sent the same day. Any delay by us to provide the documents and information within these timeframes shall not delay the conducting of the review.

Any notification that a request is not complete or eligible for external review must specify the information needed to perfect the request or reasons for ineligibility. You may appeal our determination of ineligibility to the CID to request its determination of eligibility.

A request determined to be complete and eligible will be assigned by the CID within one business day (or one calendar day, for Expedited Appeal) to an Independent Review Organization (IRO). You will be notified in writing of the acceptance of your request for review, and have the opportunity to submit any additional information in writing to the IRO.

The IRO will notify you, Cigna and the CID in writing of its decision to uphold, reverse, or revise the appealed determination within the applicable timeline below:

- for standard external reviews, 45 calendar days;
- for standard external reviews involving an experimental or investigational treatment or service, 20 calendar days;
- for expedited external reviews, 72 hours;
- for expedited external reviews involving an experimental or investigational treatment or service, five calendar days; and
- for expedited external reviews involving a Substance Use Disorder or mental disorder coverage determination, as expeditiously as the covered person's medical condition requires, but not later than 24 hours after the IRO receives the assignment from the commissioner to complete its review.

At the completion of the external review, the IRO will send notification of the decision directly to you. The IRO's decision is binding. Upon receiving any decision notice that reverses an original adverse determination, Cigna will immediately approve the coverage that was the subject of the determination.

Expedited Appeal to the State of Connecticut

You, or your provider acting on your behalf, may request an expedited appeal review with the State of Connecticut before completing Cigna's Appeal process. The expedited external appeal review request must be made at the time you receive an adverse determination and must meet the criteria outlined below:

- The time frame of a Cigna expedited Medical Necessity determination would seriously jeopardize your life or health or ability to regain maximum function; or
- Coverage was denied on the basis that the service or treatment is experimental or investigational and your treating health care professional certifies in writing that the service would be significantly less effective if not promptly started, and the person filed a request for an expedited internal review of an adverse determination; or
- An appeal determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services but has not been discharged from a facility.

You or your provider must file all necessary documentation on a prescribed state form for an expedited external appeal review.

The Connecticut Insurance Commissioner will immediately assign qualified expedited external appeal review requests to an Independent Review Organization (IRO). The IRO will conduct a preliminary review of the appeal and accept the

appeal for expedited review within one calendar day after receipt of the appeal. The IRO will immediately notify you or your provider in writing as to whether your appeal has been accepted for full review and if not accepted, the reasons why the appeal was not accepted for full review.

The IRO will complete its full review not later than 72 hours after the completion of its preliminary review (or not later than five calendar days for a review of experimental or investigational services). For expedited reviews of requests for services and treatment for mental and Substance Use Disorders, the IRO will complete its full review within 24 hours. The IRO will send notification of the decision directly to you, and forward its decision and its report of the full review to the Connecticut Insurance Commissioner. The external review entity may request from the Commissioner an extension of time to complete its review due to circumstances beyond its control. If the extension is granted, the IRO will provide written notice to you or your provider of the delay.

Please Note: An expedited external appeal review is not available for a health care service that has already been provided. If a request for an expedited external appeal review is denied, you or your provider may submit a standard external appeal review request as described in the section **Assistance from the State of Connecticut**.

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, including the date of service, if applicable, the health care professional and the claim amount; the specific reason or reasons for the adverse determination, including any applicable Medical Necessity denial code and its corresponding meaning, and our reviewer's understanding of the appeal; a description of our decision in clear terms, and reference to the specific plan provisions and/or scientific or clinical rationale 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 the procedures to initiate the next level of appeal; 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; if our own criteria is used for a Substance Use Disorder or mental disorder coverage review, a link to our website documentation regarding that Substance Use Disorder or mental disorder criteria; the titles and qualifying credentials of the individuals participating in the review process; and information about the Office of the Healthcare Advocate and health insurance consumer assistance 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 appeal decision. 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.

Contacting the State of Connecticut

In addition to the procedures described above, you have the right to contact the Connecticut Insurance Department and Office of the Healthcare Advocate at any time.

State of Connecticut
Insurance Department, Consumer Affairs Unit
P.O. Box 816
Hartford, CT 06142-0816

Phone: (860) 297-3900, 1-800-203-3447
Fax: (860) 297-3872
E-mail: cid.ca@ct.gov

Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144

Phone: Toll Free at: 1-866-HMO-4446
Fax: (860) 297-3992
E-mail: Healthcare.advocate@ct.gov

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. However, a court may require you to complete the Appeals Procedure before proceeding with such a civil action. However, no action will be brought at all unless brought

within three years after proof of claim is required under the Plan.

The definition of Dependent in the Definitions section of your certificate is amended as follows:

Dependent

Dependents are:

- your lawful spouse who is eligible for Medicare; and
- any child of yours who is eligible for Medicare by reason of disability who is:
  - primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.
  - proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.
- the term child means a child born to you or a child legally adopted by you who is entitled to Medicare by reason of disability including that child from the date of placement in your home if the child is dependent on you for support and maintenance. It also includes a stepchild who is entitled to Medicare by reason of disability.
- no one may be considered as a Dependent of more than one Employee.

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