Monroe Board of Education

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2013

ETMSURR13
3333054

This document printed in December, 2012 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

CONNECTICUT GENERAL LIFE INSURANCE COMPANY a Cigna COMPANY (called CG)

CERTIFICATE RIDER

Policyholder: Monroe Board of Education
Rider Eligibility: Each Eligible Person
Policy No. or Nos.: 3333054
Effective Date: January 1, 2013

This certificate rider forms a part of the certificate issued to you by CG describing the benefits provided under the policy(ies) specified above. This certificate rider takes the place of any other issued to you on a prior date.

IMPORTANT INFORMATION

For Residents of States other than the State of Connecticut:

For residents of states other than the State of Connecticut, there is a state-specific certificate rider that contains provisions which add to or which change your certificate provisions.

NOTE: The provisions identified in your state-specific rider, incorporated herein, are applicable ONLY to an Eligible Person located in that state. The specific state for which the rider is applicable is identified at the beginning of each individual rider as part of the "Rider Eligibility" heading.

READ THE FOLLOWING

NOTE: The provisions identified in each state-specific rider incorporated herein are specifically applicable ONLY for:

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

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

Shermona Mapp, Corporate Secretary

GM6000 ETR7CEP-CMS

Connecticut General Life Insurance Company a CIGNA Company (called CG)

CERTIFICATE RIDER – Arizona Residents

Rider Eligibility: Each Eligible Person who is located in Arizona

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

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

GM6000 ETAZ-R7CEP-CMS

The following is added to your certificate:

Important Notice

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

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

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

GM6000 R8CEP V67V1-ET

Connecticut General Life Insurance Company a Cigna Company (called CG)

CERTIFICATE RIDER – California Residents

Rider Eligibility: Each Eligible Person who is located in California

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

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

GM6000 ETCA-R7CEP-CMS

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician, approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); and the services of an embryologist. Infertility is defined as a Physician diagnosed condition or the inability of opposite sex partners to achieve conception after one year of unprotected intercourse. This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are specifically excluded infertility services:

- in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and variations of these procedures;
- 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 donor sperm and eggs; and
- any experimental, investigational or unproven infertility procedures or therapies.

GM6000 R8CEP70 5ET

In the “Definitions” section of your certificate, the first bullet in the definition of Dependent is replaced with the following:

- your lawful spouse or your domestic partner who is eligible for Medicare who has registered the domestic partnership by filing a Declaration of Domestic Partnership with the California Secretary of State pursuant to Section 298 of the Family Code or an equivalent document issued by a local

agency of California, or a local agency of another state under which the partnership was created.

The sections of this certificate entitled "COBRA Continuation Rights Under Federal Law" (and “Continuation of Coverage under Cal-COBRA”) will not apply to your Domestic Partner and his or her Dependents.

GM6000 R8CEP70 8ET

Connecticut General Life Insurance Company a Cigna Company (called CG)

CERTIFICATE RIDER – Colorado Residents

Rider Eligibility: Each Eligible Person who is located in Colorado

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

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

GM6000 ETCO-R7CEP-CMS

If Dependents are covered, the following is added to the Eligibility section of your certificate.

Exception for Children

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

GM6000 R8CEP V6V6-4ETC

In the Definitions section of your certificate the definition of **Employer** is amended as follows:

Employer

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

In the Definitions section of your certificate the definition of Emergency Service Provider is added as follows:

Emergency Service Provider

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

GM6000 R8CEP V6V6-3ETC

The following is being added to the section titled **Expenses For Which a Third Party May Be Liable** in your certificate:

CG’s right to a lien on Your recovery is limited only to that amount in excess of Your full compensation for all damages arising out of the claim.

GM6000 R8CEP V6V6-6ETC

Connecticut General Life Insurance Company a Cigna Company (called CG)

CERTIFICATE RIDER – Massachusetts Residents

Rider Eligibility: Each Eligible Person who is located in Massachusetts

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

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

GM6000 ETMA-R7CEP-CMS

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

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has

been diagnosed. Services include, but are not limited to: infertility drugs, approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization and embryo placement (IVF - EP); sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurance (if any); intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility; zygote intrafallopian transfer (ZIFT); and the services of an embryologist.

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. 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;
- Any experimental, investigational or unproven infertility procedures or therapies.

- charges for the diagnosis and treatment of autism spectrum disorder. Autism spectrum disorders are any of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. These disorders include: autistic disorder; Asperger's disorder; and pervasive developmental disorders not otherwise specified.

Diagnosis includes the following: Medically Necessary assessments; evaluations, including neuropsychological evaluations; genetic testing; or other tests to diagnose whether an insured has one of the autism spectrum disorders.

Treatment includes the following care when prescribed, provided or ordered by a licensed physician or licensed psychologist who determines the care to be Medically Necessary: Habilitative or Rehabilitative; pharmacy; Psychiatric; Psychological; and therapeutic.

Habilitative or Rehabilitative care means professional counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual. Applied behavior analysis includes the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

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

Psychological care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Therapeutic care includes services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

Pharmacy care is included to the same extent that such care is provided by the policy for other medical conditions.

The guidelines used by the insurance company to determine if coverage for the diagnosis and treatment of autism spectrum disorder is Medically Necessary will be:

- developed with input from practicing physicians in the insurer's service area;
- developed in accordance with the standards adopted by national accreditation organizations;
- updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and
- evidence-based, if practicable.

In applying such guidelines, the insurer will consider the individual health care needs of the insured.

Benefits are payable on the same basis as for the diagnosis and treatment of other physical conditions. No annual or lifetime visit or dollar limits apply to the diagnosis and treatment of autism spectrum disorder.

No coverage is provided for services to an individual under: an individualized family service plan; an individualized education program; an individualized service plan; or for services related to autism spectrum disorder provided by school personnel under an individualized education program.

The "Termination of Insurance" section of your certificate is amended to include the following:

Medical Insurance For Former Spouse

A covered former spouse who is eligible for Medicare is entitled to continue coverage following a final court decree granting divorce or separate support, until the earliest of the following:

- the date you fail to make any required contribution;
- the date you are no longer insured under the group policy;
- the date Dependent Insurance cancels;
- the date your former spouse remarries;
- the date you remarry, unless you make arrangements with the Employer to continue the insurance in accordance with the paragraph below entitled "Effect of Remarriage of Employee";
- the date the court judgment no longer requires continued coverage.

Effect of Remarriage of Employee

If you remarry, an additional contribution will be required for your former spouse. You must notify your Employer of your remarriage within 30 days of the date of your remarriage and pay the additional contribution.

GM6000 R8CEP V20V1-9ET

The "Termination of Insurance" section of your certificate is amended to include the following:

Special Continuations of Medical Insurance

If your Medical Insurance terminates for any of the reasons listed below, the Medical Insurance for you and your Dependents may be continued as outlined in each specific case.

Involuntary Layoff

Medical Insurance for you and your Dependents will be continued until the earlier of: (a) 39 weeks from the date your Active Service ends, or (b) as shown in (1), (2) or (3) of the "Other Dates of Termination" section; upon payment of the required premium by you to your Employer.

After Your Death

Medical Insurance for your Dependents will be continued until the earliest of: 39 weeks from the date your insurance ceases, or as shown in (2), or (3) of the "Other Dates of Termination" section, if the required payment is made to the Employer.

Other Dates of Termination

(1) The date you become eligible for Medical Insurance under any other group policy or Medicare;

(2) The last day of a period equal to the most recent time period during which you were insured under the Employer's policy, or, in the case of Dependent Medical Insurance continuation, a period equal to the most recent time period during which you were insured for your Dependents under the Employer's policy;

(3) With respect to any one Dependent, the earlier of: (a) the date that Dependent becomes eligible for Medical Insurance under another group policy or under Medicare, or, (b) the date that Dependent no longer qualifies as a Dependent for any reason other than your death.

GM6000 R8CEP V20V1-10ET

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

Dependent

A child includes:

- a legally adopted child who is eligible for Medicare by reason of disability. Coverage for an adopted child will begin (a) on the date of the filing of a petition to adopt such child, provided the child has been residing in your home as a foster child, and for whom you have been receiving foster care payments; or (b) when a child has been placed in your home by a licensed placement agency for purposes of adoption;

The following replaces the Medically Necessary/Medical Necessity definition in the "Definitions" section of your Certificate:

Medically Necessary/Medical Necessity

The term Medically Necessary/Medical Necessity means health care services and supplies that are consistent with generally accepted principles of professional medical practice as determined by whether the service:

- is the most appropriate available supply or level of service for you in considering potential benefits and harms to the individual; and
- is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; and
- for services and interventions not in widespread use, is based on scientific evidence.

GM6000 R8CEP V20V1-11ET

Connecticut General Life Insurance Company a Cigna Company (called CG)

CERTIFICATE RIDER – New Jersey Residents

Rider Eligibility: Each Eligible Person who is located in New Jersey

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

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

GM6000 ETNJ-R7CEP-CMS

In the "Definitions: section of your certificate, the definition of Dependent is amended as follows:

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

GM6000 R8CEP V32-1ET

The following is added to your certificate:

Complaints and Administrative Appeals Regarding Contractual Benefits, Quality of Care and Services

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

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

Start with Member Services

We are here to listen and help. If you have a specific concern or complaint regarding a person, a service, the quality of care, choice of or access to providers, provider network adequacy or contractual benefits, you or your designated representative (including your treating Provider) can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

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

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

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

1. Administrative Appeals Procedure

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

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Expedited appeals will be considered by a health care professional.

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

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

Level Two Appeal

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

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review,

which will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

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

Appeal to the State of New Jersey

For appeals regarding a person, a service, the quality of care, choice of or access to providers, provider network adequacy, or the contractual benefits, if you remain dissatisfied after exhausting CG's Complaint and Appeal procedure, you may appeal to the State of New Jersey Department of Banking and Insurance and/or the State of New Jersey Department of Health and Senior Services.

Initial Determination

CG is responsible for making decisions about the appropriateness, medical necessity and efficiency of health care services provided to Members under this Certificate. All decisions to deny or limit coverage for an inpatient admission, a service, a procedure or an extension of inpatient stay, are made by a Physician.

The health care determinations made by CG are directly communicated to the treating Provider on a timely basis appropriate to the Member's medical needs. CG will not reverse its initial determination of medical necessity or appropriateness unless misrepresented or fraudulent information was submitted to CG as part of the request for health care services.

You or your designated representative (including a provider acting on your behalf with your consent) may request a written notice of an initial determination made by CG, including an explanation of the Medical Necessity Appeal process.

2. Medical Necessity Appeals Procedure

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

Level One Appeal

You have the opportunity to speak with, and may request appeal review by, CG's Physician reviewer.

For level one appeals, we will respond in writing with a decision within five working days after we receive an appeal.

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

Level Two Appeal

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

Most requests for a second review will be conducted by the Appeals Committee, which consists of Physicians and other health care professionals. Anyone involved in the prior decision may not vote on the Appeal Committtee. The committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. You may present your situation to the committee in person or by conference call.

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

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

(b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Appeal to the State of New Jersey

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

Consumer Complaints
P.O. Box 329
Trenton, NJ 08625-0329
609-292-5316

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing: (a) the procedure to initiate the next level of appeal; (b) any voluntary appeal procedures offered by the plan; and (c) the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

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

Relevant Information

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

Legal Action Following Appeals

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

If your plan is governed by New Jersey P.L.2001, c.187 (2A:53A-30 et seq), you have the right to bring action in state court accordance with that statute. You must exhaust the Independent Health Care Appeals Program procedures created pursuant to section 11 of P.L.1997, c.192 (C26:2S-11), before filing an action in state court, unless serious or significant harm to the covered person has occurred or will imminently occur, before filing an action in state court for economic and non-economic loss that occurs as a result of CG's negligence with respect to the denial of or delay in approving or providing medically necessary covered services, which denial or delay is the proximate cause of a covered person's: (1) death; (2) serious and protracted or permanent impairment of a bodily function or system; (3) loss of a body organ necessary for normal bodily function; (4) loss of a body member; (5) exacerbation of a serious or life-threatening disease or condition that results in serious or significant harm or requires substantial medical treatment; (6) a physical condition resulting in chronic and significant pain; or (7) substantial physical or mental harm which resulted in further substantial medical treatment made medically necessary by the denial or delay or care.

GM6000 R8CEP V32-2ET

Connecticut General Life Insurance Company a Cigna Company (called CG)

CERTIFICATE RIDER – Pennsylvania Residents

Rider Eligibility: Each Eligible Person who is located in the Commonwealth of Pennsylvania

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

The provisions set forth in this certificate rider comply with the legislative requirements of the Commonwealth of Pennsylvania regarding group insurance plans covering

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

GM6000 ETPA-R7CEP-CMS

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

Dependent

A child includes a legally adopted child who is eligible for Medicare by reason of disability, including that child from the date of placement in your home, regardless of whether the adoption has become final.

GM6000 R8CEP V39V3-ETC

Connecticut General Life Insurance Company a Cigna Company (called CG)

CERTIFICATE RIDER – Texas Residents

Rider Eligibility: Each Eligible Person who is located in Texas

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

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

GM6000 ETTX-R7CEP-CMS

The following notice is added to your certificate:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Connecticut General Life Insurance Company at the following toll-free telephone numbers for information or to make a complaint.

FOR MEDICAL INSURANCE QUESTIONS

1-800-244-6224

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

1-800-252-3439

You may write the Texas Department of Insurance

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

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

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

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

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

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Usted puede llamar a Connecticut General Life Insurance Company a los siguientes números de teléfono para llamadas gratuitas si desea obtener información o someter una queja.

PARA PREGUNTAS ACERCA DEL SEGURO MEDICO

1-800-244-6224

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

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas

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

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

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

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

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

GM6000 R8CEP V58V1-1ET

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

- charges for necessary cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services or community reintegration services as a result of and related to an acquired brain injury.
- charges for diagnostic and surgical treatment for conditions effecting temporomandibular joint and craniomandibular disorders which are a result of: (a) an accident; (b) trauma; (c) a congenital defect; (d) a developmental defect; or (e) a pathology.

The definition of Dependent will be modified to include the following:

A child includes your 18 or more years old grandchild who is entitled to Medicare by reason of disability and is your Dependent for federal income tax purposes at the time of application.

GM6000 R8CEP V58V1-2ET

The Following Will Apply to Residents of Texas

When You Have a Complaint or an Adverse Determination Appeal

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

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

When You Have a Complaint

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

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

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

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When a complaint is expedited, we will respond orally with a decision within the earlier of: (a) 72 hours; or (b) one working day, followed up in writing within 3 calendar days.

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

Complaint Appeals Procedure

To initiate an appeal of a complaint resolution decision, you must submit a request for an appeal in writing. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

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

We will acknowledge in writing that we have received your request within five working days after the date we receive your request for a Committee review and schedule a Committee review. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within the earlier of: (1) 72 hours; or (2) one working day, followed up in writing within three calendar days.

When You have an Adverse Determination Appeal

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

Your appeal of an Adverse Determination will be reviewed and the decision made by a health care professional not involved in the initial decision. We will respond in writing with a decision within 30 calendar days after receiving the Adverse Determination appeal request.

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

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

Independent Review Procedure

If you are not fully satisfied with the decision of CG's Adverse Determination appeal process or if you feel your condition is life-threatening, you may request that your appeal be referred to an Independent Review Organization. In addition, your treating Physician may request in writing that CG conduct a specialty review. The specialty review request must be made within 10 days of receipt of the Adverse Determination appeal decision letter. CG must complete the specialist review and send a written response within 15 days of its receipt of the request for specialty review. If the specialist upholds the initial Adverse Determination, you are still eligible to request a review by an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CG or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

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

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

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

Appeal to the State of Texas

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

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

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the denial decision; (2) reference to the specific plan provisions on which the decision is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant

Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

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

Relevant Information

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

Legal Action under Federal Law

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

GM6000 R8CEP V58V1-3ET

Connecticut General Life Insurance Company a Cigna Company (called CG)

CERTIFICATE RIDER – Vermont Residents

Rider Eligibility: Each Eligible Person who is located in Vermont

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

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

GM6000 ETVT-R7CEP-CMS

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

Cancer Clinical Trials

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

An “approved cancer clinical trial” is an organized, systematic, scientific study of therapies, tests, or other clinical interventions for purposes of treatment, palliation, or prevention of cancer in human beings.

The approved trial must:

- seek to answer a credible and specific medical or scientific question for the purpose of advancing cancer care;
- enroll only those patients for whom there is no clearly superior, noninvestigational treatment alternative;
- have available clinical or preclinical data that provides a reasonable expectation that the treatment obtained in the approved trial will be at least as effective as the noninvestigational alternative;
- be conducted under the auspices of one of the following Vermont cancer care providers: Vermont Cancer Center at Fletcher Allen Health Care, the Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center, or approved clinical trials being

administered by a Vermont hospital and its affiliated, qualified Vermont cancer care providers;

- be conducted by a facility and personnel capable of conducting such a trial by virtue of experience, training and volume of patients treated to maintain such expertise;
- be conducted under the auspices of a peer-reviewed protocol that has been approved by one of the following entities: (a) one of the National Institutes of Health (NIH); (b) an NIH-affiliated cooperative group that is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer-review program operating within the group; (c) the FDA in the form of an investigational new drug application or exemption; or (d) the federal department of Veterans Affairs or Defense.

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

- the cost of investigational new drugs that have not been approved for market for any indication by the FDA, or the costs of any drug being studied under an FDA-approved investigational new drug exemption for the purpose of expanding the drug's labeled indications.
- the costs of nonhealth care services that may be required as a result of the treatment being provided for the purposes of the approved cancer clinical trial.
- the costs of the services that are clearly inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis and performed specifically to meet the requirements of the approved cancer clinical trial.