Colby College

EXTRATERITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2015

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

Printed in U.S.A.
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CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

Policyholder: The President and Trustees of Colby College
Rider Eligibility: Each Eligible Person
Policy No. or Nos.: 3332414
Effective Date: January 1, 2015

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

IMPORTANT INFORMATION

For Residents of States other than the State of Maine:

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

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

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

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

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

Anna Krishtul, Corporate Secretary

HC-ETRDR-CMS
CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Arizona Residents

Rider Eligibility: Each Eligible Person who is located in Arizona

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

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

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 "Customer Service" or by calling 1-800-244-6224.

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

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

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

CERTIFICATE RIDER – Arkansas Residents

Rider Eligibility: Each Eligible Person who is located in Arkansas

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

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

The Schedule is amended to indicate that Medically Necessary coverage for the diagnosis and treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder (TMJ) and craniomandibular disorder is payable on the same basis as any other medical condition.

The Covered Expenses section of your certificate is amended as follows:

- coverage for Medically Necessary equipment, services, and supplies when prescribed by a Physician and administered by a licensed health care professional, for the treatment of Type I, Type II, and gestational diabetes. Coverage includes one self-management training program per lifetime per insured; and additional training due to a significant change in symptoms or condition.

- charges made for anesthesia, hospitalization services and/or ambulatory surgical facility charges performed in connection with dental procedures when such services are required to effectively perform the procedures and the patient is: a person with a serious diagnosed mental or physical condition; or a person with a significant behavioral problem as determined by their physician.

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

The colorectal screening shall involve an examination of the entire colon, including the following examinations and laboratory tests: an annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five years; a double-contrast barium enema every five years; or a colonoscopy every ten years; and any additional medically recognized screening tests for colorectal cancer required by the Director of the Department
of Health, as determined in consultation with appropriate health care organizations.

- charges for prostate cancer examinations and laboratory tests for any non-symptomatic man forty years of age or older in accordance with the National Comprehensive Cancer Guidelines.

- charges for the necessary care and treatment of loss or impairment of speech or hearing by a licensed audiologist or speech pathologist.

- charges for hearing aids in an amount of not less than $1,400 per ear every three years; and for other purposes. Hearing aid means an instrument or device, including repair and replacement parts, that is: designed and offered for the purpose of aiding persons with or compensating for impaired hearing; worn in or on the body; and generally not useful to a person in the absence of hearing impairment. Such coverage is not subject to deductibles or copayment requirements.

- charges for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed under the direction of a Physician for the Medically Necessary treatment of phenylketonuria (PKU).

- charges made for child preventive care services for a Dependent child who is age 18, consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:
  - a history;
  - physical examination;
  - development assessment;
  - anticipatory guidance;
  - appropriate immunizations, which are not subject to any copay, coinsurance, deductible, or dollar limit; and
  - laboratory tests;

excluding any charges for:

- services for which benefits are otherwise provided under this plan;

- services for which benefits are not payable according to the Exclusions section.

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

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

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

**Infertility Services**

- charges made for services related to diagnosis 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); in-vitro fertilization (IVF); 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.

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 donor sperm and eggs; and
- any experimental, investigational or unproven infertility procedures or therapies.

**Medical Benefits Extension During Hospital Confinement Upon Policy Cancellation**

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital 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 covered for medical benefits under another group plan;
the date you or your Dependent is no longer Hospital Confined; or
the date Hospital benefits are exhausted.
The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when your Medical Benefits cease or your Dependent's Medical Benefits cease.

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

CERTIFICATE RIDER – California Residents

Rider Eligibility: Each Eligible Person who is located in California
This rider forms a part of the certificate issued to you by Cigna.
The provisions set forth in this rider comply with the legal requirements of California for group insurance plans covering insureds located in California. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

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); 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:
- in vitro fertilization (IVF);
- 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.

Definitions

Domestic Partner

A Domestic Partner is defined as your Domestic Partner 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, another state, or a local agency of another state under which the partnership was created.

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

CERTIFICATE RIDER – Connecticut Residents

Rider Eligibility: Each Eligible Person who is located in Connecticut
This rider forms a part of the certificate issued to you by Cigna.
The provisions set forth in this rider comply with the legal requirements of Connecticut for group insurance plans covering insureds located in Connecticut. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.
The following is added to the medical section of your certificate entitled Covered Expenses:

- charges for medically necessary orthodontic processes and appliances for the treatment of craniofacial disorders shall be provided for individuals eighteen years of age, 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.

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

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

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

CERTIFICATE RIDER – Delaware Residents

Rider Eligibility: Each Eligible Person who is located in Delaware

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

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

Covered Expenses

- charges made for a CA-125 Monitoring of Ovarian Cancer subsequent to treatment.
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for treatment of Serious Mental Illness. Such Covered Expenses will be payable the same as for other illnesses. Any Mental Illness Maximums in the Schedule and any Full Payment Area exceptions for mental illness will not apply to Serious Mental Illness.
- scalp hair prostheses worn due to alopecia areata.
- charges made for or in connection with mammograms including; a baseline mammogram for asymptomatic women at least age 35; a mammogram every one or two years for a-symptomatic women ages 40-49, but no sooner than two years after a woman's baseline mammogram; an annual mammogram for women age 50 and over; and when prescribed by a Physician, a mammogram, anytime, regardless of the woman's age.
- charges made for an annual pap test for females 18 and over.
- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.
The provisions set forth in this rider comply with the legal requirements of Illinois for group insurance plans covering insureds located in Illinois. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

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

CERTIFICATE RIDER – Massachusetts Residents

Rider Eligibility: Each Eligible Person who is located in Massachusetts

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

The provisions set forth in this rider comply with the legal requirements of Massachusetts for 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.

The following is added to your certificate:

Mental Health Parity

This plan must cover the same or equal benefits for mental health and substance abuse conditions that it covers for other medical conditions. This is called “Mental Health Parity.” For example, if your plan offers prescription drug benefits, whether drugs are prescribed for a mental health or medical condition, they must be covered at the same rates. The copayments, deductibles, and maximum lifetime benefits charged for mental health conditions must be the same as those for medical conditions.

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. Coverage for Mental Health Services includes treatment for the following:

- Biologically-based mental disorders as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the DSM); specifically schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post traumatic stress disorder, Substance Abuse disorders, autism and any biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the commissioner of the Massachusetts Department of Mental Health in consultation with the commissioner of the Massachusetts Division of Insurance.
- Rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to commit rape, whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims.

- Nonbiologically-based mental, behavioral or emotional disorders, as described in the most recent edition of the DSM, that substantially interferes with or substantially limits the functioning and social interactions of children and adolescents under age 19. The interference or limitation must either be: documented by, and the referral for such diagnosis and treatment must be made by, the child or adolescent’s Primary Care Provider, primary pediatrician or a licensed mental health professional; or evidenced by conduct, including but not limited to, an inability to attend school as a result of the disorder; the need to hospitalize the child or adolescent as a result of the disorder; or a pattern of conduct or behavior caused by the disorder which poses a threat to the child or adolescent or to others. Benefits for treatment will continue beyond the adolescent’s 19th birthday, if the adolescent is engaged in an ongoing course of treatment, until the course of treatment is completed, so long as this health benefits plan remains in effect. Ongoing treatment, if not completed, will also be covered under any subsequent health benefit plan in effect.

- All other mental disorders not otherwise previously provided for, which are described in the most recent edition of the DSM.

Psychopharmacological services and neuropsychological assessment services are covered on the same basis as services for any other Sickness.

In determining benefits payable, charges made for the treatment of biologically-based mental disorders, rape-related mental or emotional disorders for victims of a rape or victims of an assault with intent to commit rape, or nonbiologically-based mental, behavioral or emotional disorders of children or adolescents under age 19 are not considered Mental Health Services but are payable on the same basis as for any other Sickness.

Substance Abuse is considered a biologically-based mental disorder as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the DSM).

Your Rights Under Mental Health Parity
- You have the right to coverage for the diagnosis and treatment of mental illness under the Mental Health Parity law.
- You can change your doctor or other mental health provider if you are not satisfied.
- You can see and get a copy of your medical records. You can add your own notes to your records.

Complaints Concerning Non-Compliance With Mental Health Parity
Complaints alleging a Carrier’s noncompliance with Mental Health Parity may be submitted verbally or in writing to the Division’s Consumer Services Section for review. A written submission may be made by using the Division’s Insurance Complaint Form. A copy of the form may be requested by telephone or by mail, and form can also be found on the Division’s webpage at:

http://www.mass.gov/ocabr/consumer/insurance/file-a-complaint/filing-a-complaint.html

Consumer complaints regarding alleged non-compliance with Mental Health Parity also may be submitted by telephone to the Division’s Consumer Services Section by calling (877) 563-4467 or (617) 521-7794. All complaints that are initially made verbally by telephone must be followed up by a written submission to the Consumer Services Section, which must include but is not limited to the following information requested on the Insurance Complaint Form: the complainant’s name and address; the nature of complaint; and the complainant’s signature authorizing the release of any information regarding the complaint to help the Division with its review of the complaint. The Division will endeavor to resolve all consumer complaints regarding non-compliance with the Mental Health Parity Laws in a timely fashion.

The following is added to the medical section of your certificate entitled Covered Expenses:
- charges made for nonprescription enteral formulas to treat malabsorption caused by Crohn’s disease or ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited disorders of amino and organic acid metabolism. Foods modified to be low protein for use by a person with disorders of amino and organic acid metabolism are covered to a maximum of $5,000 per year.
- charges for a scalp hair prosthesis worn for hair loss due to the treatment of any form of cancer or leukemia, provided that a Physician verifies in writing that the scalp hair prosthesis is Medically Necessary. Benefits payable will not exceed $350 per year.
- charges made for hormone replacement therapy services for peri- and postmenopausal women and for outpatient contraceptive drugs or devices which have been approved by the Food and Drug Administration (FDA), under the same terms and conditions as for other outpatient prescription drugs and devices.
charges made for or in connection with mammograms for breast cancer screening, not to exceed: one baseline mammogram for women age 35 but less than 40, and a mammogram annually for women age 40 and over.

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 Cigna 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, Cigna 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, nor will Cigna require that visits for the diagnosis and treatment of autism spectrum disorder be completed within a fixed number of days.

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.

- 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 and intrauterine insemination (IUI); diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization and embryo transfer (IVF-ET); 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); assisted hatching; cryopreservation of eggs; and the services of an embryologist.

Infertility is defined as the condition of an individual who is unable to conceive or produce conception during a period of one year for a female who is age 35 or younger, or during a period of 6 months for a female over age 35. If a person conceives, but is unable to carry that pregnancy to live birth, the period of time a woman attempted to conceive prior to achieving that pregnancy will be included in the calculation of the one year or 6 month period, as applicable. 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, including when the infertility is caused by or related to voluntary sterilization;
- medical services rendered to a covered person’s surrogate and any surrogate fees;
- donor charges and services; and
- any experimental, investigational or unproven infertility procedures or therapies, until the procedure becomes recognized as non-experimental.

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

Medical Insurance for Former Spouse
A covered former spouse is entitled to continue coverage following a final court decree granting divorce or separate support, until the earliest of the following:

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

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

Special Continuations of Medical Insurance
If your Medical Insurance terminates for 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: 39 weeks from the date your Active Service ends, or as shown in (1), (2) or (3) of the “Other Dates of Termination” section, if the required payment is made to the Employer.

Other Dates of Termination
(1) The date you become eligible for Medical Insurance under any other group policy or Medicare;
(2) The last day of a period equal to the most recent time period during which you were insured under the Employer’s policy, or, in the case of Dependent Medical Insurance continuation, a period equal to the most recent time period during which you were insured for your Dependents under the Employer’s policy;
(3) With respect to any one Dependent, the earlier of: the date that Dependent becomes eligible for Medical Insurance under another group policy or under Medicare, or the date that Dependent no longer qualifies as a Dependent for any reason other than your death.

The term “Dependent” found in the section entitled Definitions is amended as follows:

Dependent
Dependents are:
- your former spouse, unless the divorce decree provides otherwise.
A child includes:
- a legally adopted child who is eligible for Medicare by reason of disability. Coverage for an adopted child will begin: on the date of the filing of a petition to adopt such a child, provided the child has been residing in your home as a foster child, and for whom you have been receiving foster care payments; or when a child has been placed in your home by a licensed placement agency for purposes of adoption;
CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Michigan Residents

Rider Eligibility: Each Eligible Person who is located in Michigan

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

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

HC-RDR56 01-15 V2-ET-CMS

Covered Expenses

- The following benefits will be covered for prevention and treatment of diabetes:
  - charges for podiatric appliances for prevention of complications associated with diabetes, blood glucose monitors, including for the legally blind, injection aids, insulin pumps and medical supplies required for the use of an insulin pump;
  - charges for diabetes self-management training provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the Department of Health, but limited to the following:
    - visits certified as Medically Necessary when diabetes is diagnosed; and
    - visits which are certified to be Medically Necessary following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management.
  - test strips for glucose monitors, visual reading and urine testing strips, insulin, cartridges for legally blind, syringes, lancets and spring-powered lancet devices, glucagon emergency kits and nonexperimental medication for controlling blood sugar; medication used in the treatment of the feet, ankles or nails associated with diabetes.

Autism

- charges made for professional services for the diagnosis and treatment of Autism Spectrum Disorders, including Behavioral Health Treatment, Applied Behavior Analysis (ABA), Psychiatric care, Psychological care; Therapeutic care; and Pharmacy benefits (if plan includes prescription drug coverage) that develop, maintain, or restore to the maximum extent practicable, the functioning of an individual with Autism.

Cigna, as a condition of coverage may:

- require a review of the treatment consistent with current protocols and may, at its own expense, require a review of the Treatment plan;
- request the results of the Autism Diagnostic Observation Schedule that has been used in the diagnosis of an Autism Spectrum Disorder;
- request that the Autism Diagnostic Observation Schedule be performed not more frequently than once every three years; and
- request that an annual development evaluation be conducted and the results of that annual development evaluation be submitted to Cigna.

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Autism Diagnostic Observation Schedule means the protocol available through western psychological services for diagnosing and assessing Autism Spectrum Disorders or any other standardized diagnostic measure for Autism Spectrum Disorders that is approved by the commissioner of insurance, if the commissioner of insurance determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

Autism Spectrum Disorders means Autistic Disorder, Asperger’s Disorder, and Pervasive Developmental Disorder not otherwise specified, in accordance with the Diagnostic and Statistical Manual (DSM).

Behavioral Health Treatment means evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

- Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
- Are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.
- charges made for any drug approved by the FDA on the basis that the drug has not been approved for the treatment
of the particular condition for which the drug has been prescribed. A drug and supplies Medically Necessary to administer the drug must be covered provided the following conditions are met:

- the drug is approved by the FDA;
- the drug is prescribed by an allopathic or osteopathic Physician for the treatment of a life threatening condition or a chronic and seriously debilitating condition as long as the drug is Medically Necessary to treat that condition and the drug is on the plan formulary or accessible through formulary procedures; and
- the drug has been recognized for the specific indication prescribed in any one of the following: the American Medical Association Drug Evaluations; the American Hospital Formulary Service Drug Information; the United States Pharmacopoeia Drug Information or any two articles from major peer-reviewed medical journals.

The following provisions are added to the Covered Expenses section of your certificate:

- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).

- charges for diagnosis and treatment of autism spectrum disorders for a covered child 18 years of age or younger. Coverage must be provided to a child who is diagnosed with one of the following disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:
  - autistic disorder;
  - Asperger's disorder; or
  - pervasive developmental disorder not otherwise specified.

Coverage under this section includes:

- habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed physician or licensed psychologist, including but not limited to professional, counseling, and guidance services and treatment programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child;
- medications prescribed by a physician licensed under Title 37, chapter 3;
- psychiatric or psychological care; and
- therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist licensed in this state.

Habilitative and rehabilitative care includes medically necessary interactive therapies derived from evidence-based research, including applied behavior analysis, which is also known as Lovaas therapy, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

Applied behavior analysis covered under this section must be provided by an individual who is licensed by the behavior analyst certification board or is certified by the department of public health and human services as a family support specialist with an autism endorsement.

When treatment is expected to require continued services, Cigna may request that the treating physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is medically necessary. The treatment plan must be based on evidence-based screening criteria. Cigna may ask that the treatment plan be updated every 6 months.
As used in this section, **medically necessary** means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a physician or psychologist licensed in this state and that will or is reasonably expected to:

- prevent the onset of an illness, condition, injury, or disability;
- reduce or improve the physical, mental, or developmental effects of an illness, condition, injury, or disability; or
- assist in achieving maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same age.

- coverage for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist. Coverage must include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

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**The Schedule**

**TMJ Surgical and Non-surgical treatment is payable on the same basis as any other medical condition.**

**Covered Expenses**

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

**Cleft Lip and Palate**

- charges for treatment of cleft lip and cleft palate to correct congenital defects or anomalies.

**Bone Mass Measurement Test**

- charges for a qualified person for the diagnosis and evaluation of osteoporosis or low bone mass if at least 23 months have elapsed since the last Bone Mass Measurement was performed. More frequent follow up measurements will be covered when deemed Medically Necessary. Conditions that would be considered Medically Necessary include, but are not limited to: monitoring insureds on long-term glucocorticoid therapy of more than 3 months; or a central Bone Mass Measurement to determine the effectiveness of adding an additional treatment program for a qualified person with low bone mass as long as the Bone Mass Measurement is performed 12 to 18 months from the start date of the additional program.

A Qualified Person means one who:

- is estrogen deficient and at clinical risk for osteoporosis or low bone mass;
- is experiencing radiographic ostiopenia anywhere in the skeleton;
- is receiving long-term glucocorticoid (steroid) therapy;
- is having primary hyperparathyroidism;
• is being monitored to assess the response to commonly accepted osteoporosis drug therapies;
• has a history of low-trauma fractures;
• has other conditions or is on medical therapies known to cause osteoporosis or low bone mass.

**Temporomandibular Joint Dysfunction**

• charges made for surgical and nonsurgical care of Temporomandibular Joint Dysfunction (TMJ) excluding appliances and orthodontic treatment.

**Hospital Charges for Anesthesia**

• charges made by a Hospital or ambulatory surgical facility for anesthesia and facility charges for services performed in the facility in connection with dental procedures for covered persons with serious mental or physical conditions; or covered persons with significant behavioral problems. The treating provider must certify that hospitalization or general anesthesia is required in order to safely and effectively perform the procedure because of the person's age, condition or problem.

**Mothers and Newborns**

• charges for treatment of mothers and newborns for a minimum of 48 hours of inpatient length of stay following a normal vaginal delivery, and a minimum of 96 hours of inpatient length of stay following a cesarean section, without requirement that the attending Physician obtain authorization from Cigna.

**Breast Reconstruction and Breast Prostheses**

• charges made for reconstructive surgery at any time following a mastectomy, regardless of the length of time lapsed between the mastectomy and reconstruction; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bras and external prosthetics. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

**Post Mastectomy Inpatient Care**

The decision to discharge a patient from a Hospital following a mastectomy will be made by the attending Physician in consultation with the patient based on the health and medical history of the patient.

**Definitions**

**Dependent**

The definition of Dependent will include an adopted child from the moment of placement in the adoptive home whether or not the adoption becomes final, or a foster child, who is entitled to Medicare. Proof of incapacity for a physically or mentally handicapped child will not be requested more frequently than annually during the period following the date the child reaches the limiting age. For a Dependent enrolled due to a court of administration order, any requirement that the Dependent be primarily dependent on the insured for support and maintenance.

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

**CERTIFICATE RIDER – Pennsylvania Residents**

Rider Eligibility: Each Eligible Person who is located in Pennsylvania

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

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

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

• charges made for or in connection with mammograms for breast cancer screening and diagnosis, not to exceed: a baseline mammogram annually for women age 40 and over; and a mammogram upon a Physician's recommendation for women under age 40.

• charges for an annual gynecological exam, including a pelvic exam and a routine Pap smear. No dollar limit or deductible may be applied to routine Pap smears.

• charges for childhood immunizations, including the immunizing agents and Medically Necessary booster doses. Immunizations provided in accordance with Advisory Committee on Immunization Practices (ACIP) standards are covered for any insured person under age 21 who is eligible for Medicare by reason of disability and are exempt from deductibles or dollar limits.

• charges for Medically Necessary nutritional supplements for the treatment of phenylketonuria (PKU), branched-chain
ketonuria, galactosemia, and homocystinuria when administered under the direction of a Physician. A deductible will not apply.

- The following benefits will apply to insulin-dependent, and noninsulin-dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:
  - charges for Durable Medical Equipment, including glucometers; blood glucose monitors for the legally blind; insulin pumps; infusion devices and related accessories, including those adaptable for the legally blind; podiatric appliances; and glucagon emergency kits. A special maximum will not apply.
  - charges for insulin; syringes; needles; prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips; urine test strips; lancets; and alcohol swabs.
  - charges for training by a Physician with expertise in diabetes management, but limited to the following:
    - Medically Necessary visits when diabetes is diagnosed;
    - Medically Necessary visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
    - visits when reeducation or refresher training is prescribed by the Physician; and
    - medical nutrition therapy related to diabetes management.

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

**Dependent**
The term child includes a child legally adopted by you 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.

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

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

- charges made for a mammogram: once for women ages 35 to 39; once every two years for women ages 40 to 49; and once a year for women who are at least 50.

The following benefits will be covered for treatment of diabetes mellitus:

- charges for podiatric appliances for prevention of complications associated with diabetes, blood glucose monitors, including for the legally blind, injection aids, insulin pumps and insulin infusion devices and accessories;
- charges for training by a Physician, but limited to the following:
  - visits certified by a Physician as Medically Necessary when diabetes is diagnosed;
  - visits which are certified by a Physician to be Medically Necessary following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management; and
  - visits which are certified by a Physician to be Medically Necessary for reeducation or refresher training.
- test strips for glucose monitors, visual reading and urine testing strips, insulin, cartridges for legally blind, syringes, glucagon emergency kits and oral agents for controlling blood sugar.
- charges made for Medically Necessary care and treatment of cleft lip and palate and any condition or illness which is related to or developed as a result of cleft lip and palate. This includes, but is not limited to, oral/facial surgery, teeth capping prosthodontics, orthodontics, otolaryngology, and audiological care.

The following **Medical Benefits Extension** provision is added to your certificate:

**Medical Benefits Extension**

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

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

**Totally Disabled**

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

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

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

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

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 definition of **Dependent** in your certificate includes the following:

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

**Covered Expenses**

- charges for a diagnostic screening for prostate cancer including an annual diagnostic examination, including a digital rectal examination and a prostate-specific antigen test for: asymptomatic men age 50 and over; and men age 45 and over who are at high risk for prostate cancer. Coverage will also be provided for medically indicated diagnostic testing at intervals recommended by a Physician, including the digital rectal examination, prostate-specific antigen test and bone scan for males of any age who have a prior history of prostate cancer.
- charges made by a Hospital or Ambulatory Surgical Facility (including a dental office) for anesthesia and facility charges for dental care provided to a covered person who is severely disabled or otherwise suffers from a developmental disability which places the person at serious risk, as determined by a Physician.
- Coverage is provided for Medically Necessary equipment, supplies, and self-management training and education, including medical nutrition therapy, for the treatment of diabetes if prescribed by a physician or other licensed health care provider legally authorized to prescribe such treatment. Covered Expenses include:
  - charges for the following pharmaceutical supplies: insulin, prescribed oral agents for controlling blood sugars, glucose agents, test strips for glucose monitors, urine testing strips, injection aids, lancets, syringes and alcohol swabs.
- charges for the following equipment: blood glucose monitors, blood glucose monitors for the legally blind, lancet devices, insulin pumps and all supplies for the pump, insulin infusion devices, glucagon kits, insulin measurement and administration aids for the visually impaired, and other medical devices for treatment of diabetes.

- charges for self-management training and education, including medical nutrition therapy. Medical nutrition therapy does not include any food items or nonprescription drugs.

Such training must be provided by a Physician, Nurse, dietician, pharmacist or other licensed health care provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetic Educators. The provider must have completed a course in diabetes education recognized or approved by the American Diabetes Association or the South Dakota Department of Health or be certified as a diabetes educator.

Coverage of diabetes self-management training is limited to:

- persons who are newly diagnosed with diabetes or have received no prior diabetes education;
- persons who require a change in current therapy;
- persons who have a co-morbid condition such as heart disease or renal failure;
- persons whose diabetes condition is unstable.

Coverage is provided for no more than two comprehensive education programs per lifetime and up to eight follow-up visits per year.

Benefits for the treatment of diabetes are payable on the same basis as any other illness, including deductibles, copays, coinsurance and dollar limits.

**Exclusions**

The exclusion that reads:

“for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit”

is deleted and replaced with the following:

“for any injury or sickness for which benefits are paid under workers' compensation.”