

**Clinton Board of Education-  
Clinton Public Schools**

CIGNA VISION

**EFFECTIVE DATE: July 1, 2022**

CN012  
3342693

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

Printed in U.S.A.



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

**CIGNA HEALTH AND LIFE INSURANCE COMPANY**

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

**POLICYHOLDER: Clinton Board of Education-Clinton Public Schools**

**GROUP POLICY(S) — COVERAGE**

3342693 - VISP1 CIGNA VISION

**EFFECTIVE DATE:** July 1, 2022

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.



*Jill Stadelman, Corporate Secretary*

### **Explanation of Terms**

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

### **The Schedule**

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

## Important Notices

### Notice Regarding Provider Directories and Provider Networks - Vision

A Participating Provider network consists of a group of local practitioners who contract directly or indirectly with Cigna to provide services to members.

You may receive a listing of Participating Providers by calling the member services number on your benefit identification card, or by visiting [www.cigna.com/sites/stateofct-partnership/](http://www.cigna.com/sites/stateofct-partnership/).

### Notice - Participating Provider Benefits

The Vision benefit plan includes the following options:

- If you select a Participating Provider Cigna will base its payment on the amount listed in the Schedule of Benefits. The Participating Provider will limit his/her charge to the Contracted Fee for the service.
- If you select a Non-Participating Provider Cigna will base its payment on the amount listed in the Out-of-Network section of the Schedule of Benefits. The Non-Participating Provider may balance bill up to his/her actual charge.

### Notice – Emergency Services

Emergency Services rendered by a Non-Participating Provider will be paid at the Participating Provider benefit level in the event a Participating Provider is not available.

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### Discrimination is Against the Law

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

Cigna:

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

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

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

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

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

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

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

### Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. Call 1.877.478.7557 (TTY: 800.428.4833).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1.877.478.7557 (TTY: 800.428.4833).

**Chinese** – 注意：我們可為您免費提供語言協助服務。請致電 1.877.478.7557（聽障專線：800.428.4833）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1.877.478.7557 (TTY: 800.428.4833).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.877.478.7557 (TTY: 800.428.4833)번으로 전화해주시요.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Tumawag sa 1.877.478.7557 (TTY: 800.428.4833).

**Russian** – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

Звоните 1.877.478.7557 (линия ТТУ телетайп:  
800.428.4833).

**Arabic** – ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.877.478.7557 (رقم هاتف الصم والبكم: 800.428.4833).

French Creole – ATANSYON: Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1.877.478.7557 (TTY: 800.428.4833).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1.877.478.7557 (ATS: 800.428.4833).

Portuguese – ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue 1.877.478.7557 (TTY: 800.428.4833).

Polish – UWAGA: Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1 877 478 7557 (TTY: 800.428.4833).

Japanese –  
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.877.478.7557 (TTY: 800.428.4833) まで、お電話にてご連絡ください。

Italian – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.877.478.7557 (TTY: 800.428.4833).

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.478.7557 (TTY: 800.428.4833).

**Persian (Farsi)** – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه میشود. با شماره 1.877.478.7557 تماس بگیرید (شماره تلفن ویژه ناشنوايان: 800.428.4833).

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## How To File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the

provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by using the toll-free number on your identification card.

### CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.  
YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.  
YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

### Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 365 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 365 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

**WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

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## Eligibility - Effective Date

### Employee Insurance

This plan is offered to you as an Employee.

### Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and

- you normally work at least 30 hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

**Eligibility for Dependent Insurance**

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

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

**Waiting Period**

None.

**Classes of Eligible Employees**

Each Employee as reported to the insurance company by your Employer.

**Effective Date of Employee Insurance**

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

**Late Entrant - Employee**

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

**Dependent Insurance**

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

**Effective Date of Dependent Insurance**

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

**Late Entrant – Dependent**

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

**Exception for Newborns**

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 61 days after his birth. If you do not elect to insure your newborn child within such 61 days, coverage for that child will end on the 61st day. No benefits for expenses incurred beyond the 61st day will be payable.

**Exception for Adopted Children**

Any Dependent child placed with you for adoption while you are insured will become insured on the date of placement, provided the child lives with you and is dependent upon you for support and maintenance, and you elect Dependent Insurance no later than 31 days from the date of placement. If you do not elect to insure such child within such 31 days, coverage for that child will end on the 31<sup>st</sup> day. No benefits for expenses incurred beyond the 31<sup>st</sup> day will be payable.

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<b>Cigna Vision</b>		
<b>The Schedule</b>		
<b>For You and Your Dependents</b>		
<b>Copayments</b>		
Copayments are amounts to be paid by you or your Dependent for covered services.		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
	The Plan will pay 100% after any copayment, subject to any maximum shown below	The plan will reimburse you at 100%, subject to any maximum shown below
<b>Lenses</b> One pair per 12 Consecutive months		
Single Vision Lenses	100%	\$40
Bifocal Lenses	100%	\$65
Trifocal Lenses	100%	\$75
Lenticular Lenses	100%	\$100
Progressive Lenses	100%	\$65
<b>Contact Lenses</b> One pair per 12 Consecutive months		
Elective	100% up to \$360	\$345
Therapeutic	100%	\$345
<b>Frames</b> One pair per 12 Consecutive months	100% up to \$175	\$126

## Vision Benefits \*\*

### For You and Your Dependents

#### Covered Expenses

##### Benefits Include:

Lenses (Glasses) – One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms).

- Polycarbonate lenses for children under 19 years of age;
- Oversize lenses;
- Rose #1 and #2 solid tints;
- Progressive lenses covered up to bifocal lenses amount.

Frames – One frame – choice of frame covered up to retail plan allowance.

Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year).

Contact lens allowance can be applied towards contact lens materials as well as the cost of supplemental contact lens professional services including fitting and evaluation, up to the stated allowance.

Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakia; as determined and documented by your Vision Provider. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens benefit shown on the Schedule of Benefits.

\*\*coverage may vary at participating discount retail and membership club optical locations, please contact Customer Service for specific coverage information.

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#### Expenses Not Covered

Covered Expenses will not include, and no payment will be made for:

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.

- Charges incurred after the Policy ends or the insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- Charges in excess of the usual and customary charge for the service or materials.
- For or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.
- Any injury or illness when paid or payable by Workers' Compensation or similar law to the extent permissible by law, or which is work-related.
- Claims submitted and received in-excess of 12 months from the original date of service.
- VDT (video display terminal)/computer eyeglass benefit.
- Magnification or low vision aids.
- Spectacle lens treatments, "add ons", or lens coatings not shown as covered in The Schedule.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Prescription sunglasses.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Safety glasses or lenses required for employment.

Other Limitations are shown in the Exclusions and General Limitations section.

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## Exclusions and General Limitations

### Exclusions

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

- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- for or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.

### **General Limitations**

No payment will be made for expenses incurred for you or any one of your Dependents:

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.

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### **Coordination of Benefits**

This section applies if you or any one of your Dependents is covered under more than one Plan, and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

#### **Definitions**

For the purposes of this section, the following terms have the meanings set forth below:

##### **Plan**

Any of the following that provides benefits or services for vision care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage under any form of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

##### **Closed Panel Plan**

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

### **Primary Plan**

The Plan that pays first as determined by the Order of Benefit Determination Rules below.

### **Secondary Plan**

The Plan that pays after the Primary Plan as determined by the Order of Benefit Determination Rules below. The benefits under the Secondary Plan are reduced based on the benefits under the Primary Plan.

### **Allowable Expense**

The amount of charges considered for payment under the Plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

### **Claim Determination Period**

A calendar year or that part of a calendar year in which the person has been covered under this Plan.

### **Reasonable Cash Value**

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

### **Order of Benefit Determination Rules**

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child; and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

### **Effect on the Benefits of This Plan**

If this Plan is the Secondary Plan, it will be liable for the lesser of:

- what the secondary carrier would pay if primary, or
- the balance of the billed charge.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide services and supplies under this Policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

### **Recovery of Excess Benefits**

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

### **Right to Receive and Release Information**

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 55 days of the request, the claim will be closed. If the requested information is subsequently received, the claim will be processed.

### **Coordination of Benefits with Medicare**

If you, your spouse, or your Dependent is covered under this Plan and are enrolled in Medicare, federal law determines which Plan is the primary payer and which is the secondary payer. The primary payer always determines covered benefits first, without considering what any other coverage will pay. The secondary payer determines its coverage only after the Primary Plan has completed its determination.

#### **When Medicare is the Primary Payer**

Medicare will be the primary payer and this Plan will be the secondary payer, even if you receive services from a provider who does not accept Medicare payments, in the following situations:

- **COBRA or State Continuation**: You, your spouse, or your covered Dependent are enrolled in Medicare and are covered under this Plan due to COBRA or state continuation of coverage, except as may be applicable for End Stage Renal Disease (ESRD).
- **Retirement or Termination of Employment**: You, your spouse, or your covered Dependent are enrolled in Medicare and are covered under this Plan due to your retirement or termination of employment.
- **Disability**: You, your spouse, or your covered Dependent qualify for and are enrolled in Medicare due to a disability, you are an active Employee, and your Employer has fewer than 100 employees.
- **Age**: You, your spouse, or your covered Dependent qualify for and are enrolled in Medicare due to age, you are an active Employee, and your Employer has fewer than 20 employees.
- **End Stage Renal Disease (ESRD)**: You, your spouse, or your covered Dependent qualify for and are enrolled in Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan will be the primary payer for the first 30 months. Beginning with the 31<sup>st</sup> month, Medicare will be the primary payer.

#### **When This Plan is the Primary Payer**

This Plan will be the primary payer and Medicare will be the secondary payer in the following situations:

- **Disability**: You, your spouse, or your covered Dependent qualify for and are enrolled in Medicare due to a disability, you are an active Employee, and your Employer has 100 or more employees.
- **Age**: You, your spouse, or your covered Dependent qualify for and are enrolled in Medicare due to age, you are an active Employee, and your Employer has 20 or more employees.
- **End Stage Renal Disease (ESRD)**: You, your spouse, or your covered Dependent qualify for and are enrolled in Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan is the primary payer for the first 30 months. Beginning with the 31<sup>st</sup> month, Medicare will be the primary payer.

#### **Failure to Enroll in Medicare**

If you, your spouse, or your Dependent do not enroll in Medicare Parts A and/or B during the person's initial Medicare enrollment period, or the person opts out of coverage, the person may be subject to Medicare late enrollment penalties, which can cause a delay in coverage and result in higher Medicare premiums when the person does enroll. It can also result in a reduction in coverage under Medicare Parts A and B. If you are planning to retire or terminate employment and you will be eligible for COBRA, state Continuation, or retiree coverage under this Plan, you should enroll in Medicare before you terminate employment to avoid penalties and to receive the maximum coverage under Medicare. Please consult Medicare or the Social Security Administration for more information.

#### **Assistance with Medicare Questions**

For more information on Medicare's rules and regulations, contact Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or at [www.medicare.gov](http://www.medicare.gov). You may also contact the Social Security Administration toll-free at 1-800-772-1213, at [www.ssa.gov](http://www.ssa.gov), or call your local Social Security Administration office.

HC-COB289

01-21

## **Payment of Benefits**

### **To Whom Payable**

Medical Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the

patient. Because of Cigna's contracts with providers, all claims from contracted providers should be assigned.

When benefits are paid to your or your Dependent, you or your Dependents are responsible for reimbursing the provider.

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

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

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

### **Recovery of Overpayment**

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

### **Calculation of Covered Expenses**

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

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

HC-POB1

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v1

## **Termination of Insurance**

### **Employees**

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is cancelled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

### **Injury or Sickness**

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels your insurance.

### **Retirement**

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels the insurance.

## **Dependents**

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

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

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

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12-17

## **Federal Requirements**

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

HC-FED1

10-10

## **Qualified Medical Child Support Order (QMCSO)**

### **Eligibility for Coverage Under a QMCSO**

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

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

#### **Qualified Medical Child Support Order Defined**

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

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

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

#### **Payment of Benefits**

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

HC-FED4

10-10

#### **Effect of Section 125 Tax Regulations on This Plan**

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax

salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

#### **A. Coverage elections**

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed:

- if your Employer agrees, and you meet the criteria shown in the following Sections B through H and enroll for or change coverage within the time period established by your Employer.

#### **B. Change of status**

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

#### **C. Court order**

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

#### **D. Medicare or Medicaid eligibility/entitlement**

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

#### **E. Change in cost of coverage**

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

## **F. Changes in coverage of spouse or Dependent under another employer's plan**

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

## **G. Reduction in work hours**

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

## **H. Enrollment in a Qualified Health Plan (QHP)**

The Employee wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

HC-FED95

04-17

## **Eligibility for Coverage for Adopted Children**

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED67

09-14

## **Group Plan Coverage Instead of Medicaid**

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13

10-10

## **Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)**

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

### **Continuation of Health Insurance During Leave**

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

### **Reinstatement of Canceled Insurance Following Leave**

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

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10-17

## **Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA)**

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you



and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

### **Continuation of Coverage**

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

### **Reinstatement of Benefits (applicable to all coverages)**

If your coverage ends during the leave of absence because you do not elect USERRA at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

HC-FED18

10-10

## **Claim Determination Procedures**

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

### **Postservice Determinations**

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to

make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

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

HC-FED79

03-13

## **COBRA Continuation Rights Under Federal Law**

### **For You and Your Dependents**

#### **What is COBRA Continuation Coverage?**

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

#### **When is COBRA Continuation Available?**

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

- your termination of employment for any reason, other than gross misconduct; or
- your reduction in work hours.

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

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

### **Who is Entitled to COBRA Continuation?**

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

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

### **Secondary Qualifying Events**

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

### **Disability Extension**

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

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

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

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

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

### **Medicare Extension for Your Dependents**

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

### **Termination of COBRA Continuation**

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

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

## Employer's Notification Requirements

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

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

## How to Elect COBRA Continuation Coverage

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

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

continuation coverage in order for your Dependents to elect COBRA continuation.

## How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

## When and How to Pay COBRA Premiums

### *First payment for COBRA continuation*

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

### *Subsequent payments*

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

### *Grace periods for subsequent payments*

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated

back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

### **You Must Give Notice of Certain Qualifying Events**

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

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

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

### **Newly Acquired Dependents**

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

### **COBRA Continuation for Retirees Following Employer’s Bankruptcy**

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your

covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

### **Interaction With Other Continuation Benefits**

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

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## **Notice of an Appeal or a Grievance**

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

### **Cigna Vision Second Level Appeals Address**

Please submit your Level 2 Grievance documents to the following address:

Cigna  
NAU National Appeals Unit  
P.O. Box 188044  
Chattanooga, TN 37422

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VI

## **When You Have A Grievance Or An Appeal**

For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted. Your health care professional can appeal without designation, for coverage requests required to be initiated by the health care professional and for urgent care coverage requests. "Physician Reviewers" are licensed Physicians depending on the care, treatment or service under review.

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

## Start with Customer Service

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

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

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

## Appeals Procedure

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

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

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

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

## Appeals of Medical Necessity Decisions

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by an appropriate clinical peer or peers. A “clinical peer” is a Physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under

review, and for a mental health review concerning: a child or adolescent Substance Use Disorder or a child or adolescent mental disorder, holds a national board certification or a doctoral level psychology degree with training and clinical experience in child and adolescent Substance Use Disorder or child and adolescent mental disorder, as applicable; for an adult Substance Use Disorder or an adult mental disorder, holds a national board certification in psychiatry or a doctoral level psychology degree with training or clinical experience in the treatment of adult Substance Use Disorders or adult mental disorders, as applicable.

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

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

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

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited Cigna appeal would be detrimental to your medical condition. A request for an expedited appeal made by a health care professional with knowledge of your medical condition shall be deemed an urgent care request.

Cigna’s Physician Reviewer, or your Physician, will decide if the expedited appeal criteria apply. When an appeal is expedited, we will respond orally with a decision to you and your representative or provider within 48 hours after the required information is received or 72 hours after the appeal is received or two working days after the required information is

received if any portion of such 48 hour period falls on a weekend, followed up in writing. For expedited appeals involving any of the following substance abuse or mental disorders, a decision will be completed and communicated within 24 hours after the appeal is received:

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

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

### **Appeals of Coverage Decisions Not Based on Medical Necessity**

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

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

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

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

### **Assistance from the State of Connecticut**

If you are dissatisfied with the decision of Cigna's appeals review regarding Medical Necessity, clinical appropriateness, health care setting, level of care or effectiveness, or a rescission of coverage or determination of ineligibility for coverage, or any person who has been diagnosed with a condition that creates a life expectancy of less than two years who has been denied an otherwise covered procedure, treatment or drug on the grounds it is experimental, you, or your provider with your consent, may file a written appeal for review with the State of Connecticut, within 120 days after the determination. The external review program is a voluntary program.

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

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

Appeals to the State of Connecticut must be submitted to:

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

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

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

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

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

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

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

- for standard external reviews, 45 calendar days;
- for standard external reviews involving an experimental or investigational treatment or service, 20 calendar days;
- for expedited external reviews, 48 hours after the required information is received or 72 hours after the appeal is received if any portion of such 48 hour period falls on a weekend;
- for expedited external reviews involving an experimental or investigational treatment or service, five calendar days; and
- for expedited external reviews involving a substance abuse or mental disorder coverage determination, as expeditiously as the covered person's medical condition requires, but not later than 24 hours after the IRO receives the assignment from the commissioner to complete its review.

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

#### **Expedited Appeal to the State of Connecticut**

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

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

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

The Connecticut Insurance Commissioner will immediately assign qualified expedited external appeal review requests to an Independent Review Organization (IRO). The IRO will

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

The IRO will complete its full review not later than 48 hours after the required information is received or 72 hours after the appeal is received if any portion of such 48 hour period falls on a weekend (or not later than five calendar days for a review of experimental or investigational services). For expedited reviews of requests for services and treatment for mental and substance abuse disorders, the IRO will complete its full review within 24 hours. The IRO will send notification of the decision directly to you, and forward its decision and its report of the full review to the Connecticut Insurance Commissioner. The external review entity may request from the Commissioner an extension of time to complete its review due to circumstances beyond its control. If the extension is granted, the IRO will provide written notice to you or your provider of the delay.

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

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

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim, the date of service, if applicable, the health care professional and the claim amount; the specific reason or reasons for the adverse determination, including any applicable Medical Necessity denial code and its corresponding meaning, and our reviewer's understanding of the appeal; a description of our decision in clear terms, and reference to the specific plan provisions and/or scientific or clinical rationale on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing the procedures to initiate the next level of appeal, any voluntary appeal procedures offered by the plan; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; if our own criteria is used for a substance abuse or mental disorder coverage review, a link to our website documentation regarding that substance abuse or

mental disorder criteria; the titles and qualifying credentials of the individuals participating in the review process; and information about the Office of the Healthcare Advocate and health insurance consumer assistance available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

### Contacting the State of Connecticut

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

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

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

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

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

### Relevant Information

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

HC-APL398 M

02-20

## Definitions

### Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.

- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1095

12-17

### Dependent

Dependents are:

- your lawful spouse; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

The term "child" means a child born to you or a child legally adopted by you, including that child from the date of placement in your home if the child is dependent on you for support and maintenance. It also includes a stepchild or a child for whom you are the legal guardian and who resides with you as a member of your household.

Benefits for a Dependent child will continue until the last day of the calendar year in which the limiting age is reached.

### Federal rights may not be available to Civil Union partners or Dependents.

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

HC-DFS235

04-10

V2 M

### Employee

The term Employee means a full-time Employee of the Employer who is currently in Active Service. The term does not include Employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

HC-DFS1094

12-17



**Employer**

The term Employer means the Policyholder and all Affiliated Employers.

HC-DFSS 04-10  
VI

**Injury**

The term Injury means an accidental bodily injury.

HC-DFS12 04-10  
VI

**Medicaid**

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

HC-DFS16 04-10  
VI

**Medically Necessary/Medical Necessity**

Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:

- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or Other Health Professional;
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

In determining whether health care services, supplies, or medications are Medically Necessary, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

HC-DFS1411 01-20

**Medicare**

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

HC-DFS17 04-10  
VI

**Ophthalmologist**

The term Ophthalmologist means a person practicing ophthalmology within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

HC-DFS70 04-10  
VI

**Optician**

The term Optician means a fabricator and dispenser of eyeglasses and/or contact lenses. An optician fills prescriptions for glasses and other optical aids as specified by optometrists or ophthalmologists. The state in which an optician practices may or may not require licensure for rendering of these services.

HC-DFS71 04-10  
VI

**Optometrist**

The term Optometrist means a person practicing optometry within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

HC-DFS72

04-10

V1

**Other Health Professional**

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS1413

01-20

**Sickness – For Medical Insurance**

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

HC-DFS50

04-10

V1

**Vision Provider**

The term Vision Provider means: an optometrist, ophthalmologist, optician or a group partnership or other legally recognized aggregation of such professionals; duly licensed and in good standing with the relevant public licensing bodies to provide covered vision services within the scope of the Vision Providers' respective licenses.

HC-DFS73

04-10

V1