

## **Wesleyan University**

PRESCRIPTION DRUG BENEFITS

(Retirees Aged 65 or Older)

EFFECTIVE DATE: January 1, 2008

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This document, printed in March, 2008, takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.



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CIGNA HealthCare

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## **Important Information**

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET (OR IN ANY RIDER ATTACHED HEREUNTO) ARE SELF-INSURED BY **WESLEYAN UNIVERSITY**, WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CONNECTICUT GENERAL. HOWEVER, BECAUSE THE PLAN IS NOT INSURED BY CONNECTICUT GENERAL, ALL REFERENCES TO INSURANCE HEREIN SHALL BE UNDERSTOOD TO BE REFERENCES TO A SELF-INSURED PLAN.

FOR EXAMPLE, REFERENCES TO "CG," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN "EMPLOYER"; AND "POLICY," TO MEAN "PLAN"; AND "INSURED," TO MEAN "COVERED"; AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE" OR "BENEFITS".



### **Explanation of Terms**

You will find terms starting with capital letters throughout this document. To help you understand your benefits, most of these terms are defined within the text, or in the "Definitions" section.

Unless the context dictates otherwise, use of the male pronoun in this document will be deemed to include the female.

### **The Schedule**

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



## Eligibility – Effective Date

### Eligibility For Retiree Benefits

You will become eligible for coverage on the day you retire if you are in a Class of Eligible Retirees.

### Eligibility for Dependent Benefits

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

- the date you become eligible for yourself; or
- the date you marry.

### Classes of Eligible Retirees

Each Retiree aged 65 or older, as reported by the Employer to CG

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### Retiree Benefits

This plan is offered to you as a Retiree. To be covered, you will have to pay part of the cost.

### Effective Date of Your Benefits

You will become covered on the date you retire by signing an approved enrollment form and agreeing to make the required contribution for the benefits.

You must elect the coverage no later than 30 days after the date you become eligible in order to be covered.

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### Dependent Benefits

For your Dependent spouse to be covered, you will have to pay part of the cost of Dependent Benefits.

### Effective Date of Dependent Benefits

Coverage for your Dependent spouse will become effective on the date you elect it by signing an approved enrollment form, but no earlier than the day you become eligible for Dependent Benefits.

You must elect the coverage no later than 30 days after the date you become eligible in order to cover your Dependent spouse. Your Dependent spouse will be covered only if you are covered.

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## Prescription Drug Benefits

### The Schedule

#### For You and Your Dependent Spouse

This plan provides coverage for Prescription Drugs and Related Supplies dispensed by Participating Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependent may be required to pay a portion of Covered Expenses for Prescription Drugs and Related Supplies. That portion is the Copayment. Benefits are subject to a lifetime maximum of \$25,000 per person.

#### Copayments

Copayments are expenses to be paid by you or your Dependent spouse for Prescription Drugs and Related Supplies. A copayment is required for each 30-day supply received from a retail Participating Pharmacy, and for each 90-day supply received from a mail-order Participating Pharmacy.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
<b>Retail Prescription Drugs</b>		
Generic* drugs on the Prescription Drug List	No Charge after \$10 copay per Prescription Order	<i>Not Covered</i>
Brand-Name * drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No Charge after \$20 copay per Prescription Order	<i>Not Covered</i>
Brand-Name * drugs with a Generic equivalent; and drugs designated as non-preferred on the Prescription Drug List	No Charge after \$35 copay per Prescription Order	<i>Not Covered</i>
<b>Mail-Order Drugs</b>		
Generic * drugs on the Prescription Drug List	No Charge after \$10 copay per Prescription Order	<i>Not Covered</i>
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No Charge after \$40 copay per Prescription Order	<i>Not Covered</i>
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No Charge after \$70 copay per Prescription Order	<i>Not Covered</i>
<i>* Designated as per generally-accepted industry sources and adopted by CG</i>		



## Prescription Drug Benefits

### Coverage Provisions

If you or your Dependent spouse, while covered for Prescription Drug Benefits, incur expenses for charges made by a Pharmacy for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, CG will provide coverage for those expenses as shown in The Schedule, subject to a lifetime maximum of \$25,000 per person. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependent by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or your Dependent is issued a prescription as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by CG as if it had been filled by a Participating Pharmacy.

### Limitations

Each Prescription Order shall be limited as follows:

- up to a consecutive 30-day supply at a retail Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 90-day supply at a mail-order Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

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Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for the treatment of a specific condition. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, he or she may call, or complete the appropriate prior authorization form and fax it to CG, to request prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in CG's claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis, and on the specific Prescription Drug or Related Supply. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, you and your Physician will be notified

that coverage for the Prescription Drugs or Related Supplies is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Plan by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free telephone number on your benefit identification card.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs, until the P & T Committee clinically evaluates the Prescription Drug for a different designation.

Prescription Drugs or Related Supplies that, according to the FDA, represent an advance over available therapy will be reviewed by the P&T Committee within 6 months after FDA approval. Prescription Drugs or Related Supplies that, according to the FDA, appear to have therapeutic qualities similar to those of an already marketed drug will not be reviewed by the P&T Committee for at least 6 months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug or Related Supply.

### Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Participating Pharmacy is subject to the Copayment shown in The Schedule. Please refer to The Schedule for any required Copayments.

When a treatment regimen contains two or more types of Prescription Drugs which are packaged together for the convenience of you or your Dependent, a Copayment will apply to each Prescription Drug.

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### Exclusions

No payment will be made for the following expenses:

- drugs, available over-the-counter, that do not require a prescription by federal or state law;
- any drug that is a pharmaceutical alternative to an over-the-counter drug (other than insulin);
- drugs in a drug class in which at least one of the drugs is available over the counter, and the drugs in that class are deemed to be therapeutically equivalent, as determined by the P&T Committee;
- any charges incurred for a person due to Prescription Drugs or Related Supplies after benefits totaling \$25,000 have been paid for him in his lifetime.
- any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The



following are examples of Physician-supervised injectable drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables, and endocrine and metabolic agents.

- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information; The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information), or in medical literature. Medical literature means scientific studies published in a peer-reviewed, national, professional medical journal;
- prescription and non-prescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasm, and decreased libido;
- prescription vitamins (other than prenatal vitamins), dietary supplements, and fluoride products;
- drugs used for cosmetic purposes, such as reducing wrinkles, promoting hair growth, controlling perspiration; as well as fade cream products;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by (or administered to) you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue.

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### Reimbursement/Filing a Claim

When you or your Dependent purchase Prescription Drugs or Related Supplies from a retail Participating Pharmacy, you pay any applicable Copayment shown in The Schedule at the time of purchase. You do not need to file a claim form.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see your mail-order drug introductory kit for details, or contact Member Services for assistance.

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### Limitations and 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:

- to the extent that you or your Dependent is in any way paid or entitled to payment for those expenses by or through a public program (other than Medicaid).
- to the extent that payment is unlawful where a person resides when the expenses are incurred.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- charges which you are not obligated to pay; or for which you are not billed; or for which you would not have been billed, except that they were covered under this plan.
- for or in connection with experimental, investigational or unproven services.

Experimental, investigational and unproven supplies are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by CG to be:

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- the subject of review or approval by an Institutional Review Board for the proposed use; or
- the subject of an ongoing Phase I, II, or III clinical trial.
- Prescription Drugs for you or your Dependent spouse, when payment is denied by Medicare because the Prescription Drugs were purchased from a non-participating pharmacy.
- Prescription Drugs, when this plan is Secondary and payment is denied by a Primary Plan because such drugs were purchased from a non-participating provider under that plan.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- for charges which would not have been made if the person had no coverage.



- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling for business or pleasure.
- charges made by any covered provider who is a member of your family or your Dependent's family.

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## Coordination of Benefits

This section applies if you or your Dependent spouse are 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 medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured, which can neither be purchased by the general public, nor 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 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 benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes coverage for services rendered 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 provides or pays benefits without taking into consideration the existence of any other Plan.

#### Secondary Plan

A Plan that determines its benefits after the benefits provided or paid by the Primary Plan (and that may reduce its benefits accordingly). Secondary Plans may also recover from Primary Plans the Reasonable Cash Value of any services they provided.

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#### Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance, or copayments, that is covered, in full or in part, by any Plan covering a person. When a 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 a person is covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If a person is covered by one Plan that provides services or supplies on the basis of reasonable and customary fees, and another Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If a person's 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 he did not comply with Plan provisions; or because he did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include pre-authorization of services.

#### Claim Determination Period

The term Claim Determination Period means a calendar year, but does not include any part of such a year during which a person is not covered under this plan; or any date before this section or any similar provision takes effect.

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#### 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 rendered under similar or comparable circumstances by other health care providers located within the immediate geographic area.

#### 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 a Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation will be utilized:

- The Plan that covers a person as an enrollee (i.e., an active or retired employee) shall be the Primary Plan, and the Plan that covers that person as a Dependent shall be the Secondary Plan;
- The Plan that covers a person as an active employee (or as a Dependent thereof) shall be the Primary Plan, and the Plan that covers that person as laid-off or retired employee (or as a Dependent thereof) shall be the Secondary Plan. If the other

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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 a person under a right of continuation which is provided by federal or state law shall be the Secondary Plan, and the Plan that covers that person as an active employee or retiree (or as a Dependent thereof) 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 a person is governed by the laws of the state whose laws govern this Plan; and that Plan 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 an insured 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, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

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 the insured. CG will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

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

- the extent of the Plan's obligation to provide coverage for services and supplies;
- whether a benefit reserve has been recorded for the insured; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

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

#### **Recovery of Excess Benefits**

If CG pays benefits for charges that should have been paid by the Primary Plan; or if CG pays benefits in excess of those for which it is obligated to provide under the Plan; CG will have the right to recover the actual payment made (or the Reasonable Cash Value of any services).

CG will have sole discretion to seek such recovery from any person to or for whom, or with respect to whom, benefits for such services were provided, or such payments made, by any insurance company, health care plan, or other organization. If requested, the person must execute and deliver to CG such instruments and documents as it determines are necessary to secure the right of recovery.

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

CG, without consent or notice, may obtain information from, and release information to, any other Plan in order to coordinate benefits pursuant to this section. Persons covered under this Plan must provide CG with any information it requests in order to coordinate benefits pursuant to this section. This request may occur in conjunction with a submitted claim; if so, the person will be advised that "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 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed at that time.

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

This plan does not cover:

1. Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
2. Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

#### **Subrogation/Right of Reimbursement**

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

1. Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant



may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.

2. **Right of Reimbursement:** The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

#### **Lien of the Plan**

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

#### **Additional Terms**

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by

any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".

- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

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## **Termination of Benefits**

### **Retiree**

Your coverage will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Retirees or otherwise cease to qualify for the coverage.
- the last day for which you have made any required contribution for the benefits.
- the date the plan is canceled.

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### **Dependent Spouse**

Benefits for your Dependent spouse will cease on the earliest date below:

- the date your coverage ceases.
- the date you cease to be eligible for Dependent Benefits.
- the last day for which you have made any required contribution for the coverage.
- the date Dependent Benefits are canceled.

Benefits for your Dependent spouse will cease on the date that Dependent no longer qualifies as a Dependent.

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## 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.

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## Notice Regarding Pharmacy Directories and Pharmacy Networks

If your Plan utilizes a network of Pharmacies, a separate listing of Participating Pharmacies can be obtained by contacting member services at the telephone number shown on the back of your benefit identification card, or by accessing [www.cigna.com](http://www.cigna.com). See your Plan Administrator if you have any questions.

The Participating Pharmacy network consists of a group of local Participating Pharmacies employed by, or contracted with, CIGNA HealthCare.

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## Notice of Pharmacy Formulary Exception Process/Prior Authorization – Coverage of New Drugs

The following applies if your Pharmacy coverage includes a closed formulary.

### Pharmacy Formulary Exception Process/Prior Authorization

For plans which provide benefits for prescription drugs only on CIGNA's formulary, covered persons may be entitled to nonformulary drugs. Additionally, there are certain medications for which prior authorization is required.

If the attending Physician believes a nonformulary drug is necessary, or wishes to prescribe a medication for which prior authorization is required, the appropriate number to call is the 1-800 number shown on your Benefit Identification card. Your Physician may need to contact National Managed Care at 1-800-832-3211 or CIGNA Pharmacy Services at 1-800-622-5579. Forms are available on our website [www.cigna.com](http://www.cigna.com), to request a formulary exception or prior authorization for the prescription. Your Physician should make this request before writing the prescription.

The pharmacist may then contact your Physician to discuss the medication and possible treatment alternatives. If the pharmacist and your Physician determine that no alternatives are appropriate, your Physician can begin the exception process.

The pharmacist or your Physician may contact one of the CIGNA HealthCare Pharmacy Exception Centers. The Exception Center will review your benefits, and determine whether or not to grant an exception.

The exception process is generally completed within 48 hours. Some exceptions may take longer, depending on the clinical pharmacist's ability to contact the retail pharmacist or your

Physician for the additional information. If you disagree with a coverage decision, you may appeal that decision by submitting a written request stating why the prescription should be covered based on your policy.

### Coverage of New Drugs

The CIGNA HealthCare drug formulary (list of preferred drugs) was developed by the CIGNA HealthCare Pharmacy and Therapeutics Committee "Committee" which is a panel of Physicians and pharmacists. The Committee regularly reviews and updates the formulary based on the latest information available about each drug's effectiveness.

All newly approved drugs are designated nonformulary/nonpreferred until the Committee evaluates the drug clinically and considers whether it should be placed on the formulary. Drugs that represent an advance over an available therapy according to the Federal Drug Administration (FDA) will be reviewed by the Committee within six months after FDA approval. Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a drug.

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

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

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the



Employee but not currently enrolled in the Plan are not entitled to special enrollment.

- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: (a) due to failure of the employer or other responsible entity to remit premiums on a timely basis; (b) when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or (c) when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions

toward COBRA or other continuation coverage as provided under any severance or other agreement.

FDRL3

V3

Special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Individuals who enroll in the Plan due to a special enrollment event will not be considered Late Entrants. Any Pre-existing Condition limitation will be applied upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

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

FDRL4

V2

### Federal Tax Implications for Dependent Coverage

Contributory payments for Dependent health coverage are usually exempt from federal income tax. Generally, if you can claim an individual as a Dependent for purposes of federal income tax, then the cost for that Dependent's health coverage will not be taxable to you as income. However, in the rare instance that you cover an individual under your health benefits who does not meet the federal definition of a Dependent, the cost may be taxable to you as income. If you have questions concerning your specific situation, you should consult your own tax consultant, CPA, or attorney.

FDRL7 M

### Group Plan Coverage Instead of Medicaid

If your income does not exceed 100% of the official poverty line and your liquid resources are at (or below) twice the Social Security income level, 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.

FDRL10

### Obtaining a Certificate of Creditable Coverage Under This Plan

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get



special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call the toll-free customer service number on the back of your ID card.

FDRL50

## Claim Determination Procedures Under ERISA

**The following complies with federal law effective July 1, 2002. Provisions of the laws of your state may supersede.**

### Procedures Regarding Medical Necessity Determinations

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

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

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

### Preservice Medical Necessity Determinations

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

If the determination periods above would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without

the requested services, CG will make the preservice determination on an expedited basis. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. CG will notify you or your representative of an expedited determination within 72 hours after receiving the request.

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

If you or your representative fails to follow CG's procedures for requesting a required pre-service Medical Necessity determination, CG will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

### Concurrent Medical Necessity Determinations

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

### Post-Service Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, CG 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 CG's control, CG 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 CG within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

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### **Post-Service Claim Determinations**

When you or your representative requests payment for services which have been rendered, CG will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control, CG 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 within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

### **Notice of Adverse Determination**

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding your claim; (6) an explanation of the scientific or clinical judgment for a determination that is based on Medical Necessity, experimental treatment, or other similar exclusion or limit; and (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

FDRL36 M

### **When You Have a Complaint or an Appeal**

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

"Physician Reviewers" are licensed Physicians specializing in the care, service, or treatment under review.

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

### **Start With Member Services**

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call the toll-free telephone number on your benefit

identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You may also express that concern in writing.

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 may start the appeals procedure.

### **Appeals Procedure**

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

### **Level One Appeal**

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

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

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

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### **Level-Two Appeal**

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

Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical



appropriateness the Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level-two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

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

### **Independent Review Procedure**

If you are not fully satisfied with the decision of CG's level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare, or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG.

Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

FDRL63

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of the level-two appeal review denial. CG will then forward the file to the Independent Review organization. The Independent Review Organization will render an opinion within 30 days. When requested, and when a delay would

be detrimental to your medical condition (as determined by CG's Physician reviewer), the review shall be completed within 3 days. The Independent Review Program is a voluntary program.

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

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other Relevant Information, as defined; (4) a statement describing any voluntary appeal procedures offered by the plan; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding your appeal; and (6) an explanation of the scientific or clinical judgment for a determination that is based on Medical Necessity, experimental treatment, or other similar exclusion or limit.

You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to determine what options may be available to you is to contact your local U.S. Department of Labor office, or your state insurance regulatory agency. You may also contact the Plan Administrator.

### **Relevant Information**

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

### **Legal Action**

In most instances, you may not initiate a legal action against CG until you have completed the Level One and Level Two appeal processes. If your appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

FDRL40 M

## **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, same sex spouses, 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.

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**Medicare Extension for Your Dependents**

If you enroll in Medicare (Part A, Part B, or both) within the 18-month period following your retirement date, your Dependent will be eligible for COBRA continuation coverage for up to 36 months from the date you become enrolled in Medicare.

FDRL21 M

**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: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

**Moving Out of Employer's Service Area or Elimination of a Service Area (for Employees enrolled in an In and Out-of-Network Plan)**

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer's service area. If the Employer offers another benefit option through CIGNA or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

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**Employer's Notification Requirements**

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

- An initial notification of COBRA continuation rights must be provided within 90 days after coverage for you (or your spouse) under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If your Dependent experiences 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 Dependent within the following timeframes:

- (a) 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;

- (b) 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
- (c) 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 cost. The notice will also include instructions for electing COBRA continuation coverage. The Plan Administrator must be notified of your Dependent's 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 proper notification is not made by the due date shown on the notice, your Dependent will lose the right to elect COBRA continuation coverage. If your Dependent rejects COBRA continuation coverage before the due date, he or she may change their mind as long as a completed election form is furnished before the due date.

A qualified beneficiary has an independent right to elect COBRA continuation coverage.

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### 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.

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V2

### 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;
- Your child ceases to qualify as a Dependent under the Plan; or
- 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.

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**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 that may be applicable.

FDRL26 M

**ERISA Required Information**

The name of the Plan is:

Wesleyan University Group Insurance Program

The name, address, ZIP code, and business telephone number of the sponsor of the Plan is:

Wesleyan University  
212 College Street  
Middletown, CT 06459-0418  
(860) 685-4889

Employer Identification  
Number (EIN)

06-0646959

Plan Number

511

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for the service of legal process is:

Employer named above (may be Plan trustee, if any; or Plan Administrator.)

The office designated to consider the appeal of denied claims is:

The CG claim office responsible for this Plan

The cost of the Plan is shared by Retiree and Employer.

The Plan's fiscal year ends on December 31<sup>st</sup>.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

**Plan Trustees**

A list of any Trustees of the Plan (if any), which includes name, title and address, is available upon request from the Plan Administrator.

**Plan Type**

The plan is a health care benefit plan.

**Collective Bargaining Agreements**

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

FDRL27 M

**Plan Modification, Amendment and Termination**

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan; to change or terminate the classes of eligibility to be covered by the Plan; to amend or eliminate any other plan term or condition; and to terminate the whole plan or any part of it. The procedure by which benefits may be changed or terminated; by the which the classes of eligibility may be changed or terminated; or by which part or all of the Plan may be terminated; is contained in the Employer’s Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. No consent of any participant is required to terminate, modify, amend or change the Plan.

**Statement of Rights**

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

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**Receive Information About Your Plan and Benefits**

- examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance



contracts and collective bargaining agreements and copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.

- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

**Continue Group Health Plan Coverage**

- continue health care coverage for yourself or your Dependent spouse if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependent may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan; when you become entitled to elect federal continuation coverage; when your federal continuation coverage ceases (if you request it before losing coverage); or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If you claim for a welfare benefit is denied or ignored, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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**Enforce Your Rights**

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials

and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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**Definitions**

**Dependent**

The term Dependent refers to your lawful spouse.

Anyone who is covered as a Retiree will not be covered as a Dependent.

DFS57

**Employer**

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf CG is providing claim administration services.

DFS1595

**Injury**

The term Injury means an accidental bodily injury.

DFS147

**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).

DFS192

### **Medically Necessary/Medical Necessity**

Medically Necessary services and supplies are those determined by CG to be:

- required to diagnose or treat a Sickness, 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 Care Professional; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Where applicable, CG may compare the cost-effectiveness of alternative services, settings, or supplies when determining the least intensive setting.

DFS1529

### **Medicare**

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

DFS149

### **Participating Pharmacy**

The term Participating Pharmacy means a retail or a mail-order Pharmacy with which CG has contracted to provide prescription services.

DFS1937

### **Pharmacy**

The term Pharmacy means a retail or a mail-order pharmacy.

DFS1934

### **Pharmacy & Therapeutics (P & T) Committee**

The Pharmacy & Therapeutics Committee is a committee of Participating Providers, medical directors, and Pharmacy directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to, or deletion from, the Prescription Drug List, and may also set dosage and/or dispensing limits for Prescription Drugs and Related Supplies.

DFS1919

### **Prescription Drug List**

The term Prescription Drug List refers to a listing of Prescription Drugs and Related Supplies approved by CG. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

DFS1924

### **Prescription Drug**

The Prescription Drug means: (a) a drug which has been approved by the Food and Drug Administration (FDA) for safety and efficacy; (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs, marketed prior to 1938 and not subject to review, which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

DFS1708

### **Prescription Order**

The term Prescription Order means the lawful authorization for dispensation of a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of professional practice; or any authorized refill thereof.

DFS1711

### **Related Supplies**

Related Supplies includes, but is not limited to: Diabetic supplies (insulin needles and syringes, lancets, and glucose test strips); needles and syringes for injectables covered under the pharmacy plan; and spacers for use with oral inhalers.

DFS1710

### **Retiree**

The term Retiree means a person formerly working for the Employer whose active service ceases due to voluntary retirement.

DFS1427

### **Sickness**

The term Sickness means a physical or mental illness. It also includes pregnancy.

DFS531