

# **Wesleyan University**

CIGNA VISION

**EFFECTIVE DATE: January 1, 2021**

ASO88  
3188492

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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## **Important Information**

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY WESLEYAN UNIVERSITY WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

### **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.myCigna.com](http://www.myCigna.com).

### 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 pay any required contribution.

FACULTY MEMBERS/PROFESSIONAL LIBRARIANS covered if appointed for at least half time (.5FTE or more).

ADMINISTRATIVE STAFF MEMBERS covered if regularly scheduled to work at least three quarter time (at least 1462.5 hours per year).

Secretarial/Clerical/Physical Plant/Public Safety Members: Covered if appointed for at least three quarter time on a non-temporary basis.

DOCTORS AND NURSES EMPLOYED BY THE HEALTH CENTER covered if appointed for at least .5FTE (975 hours) and their employment is expected to last for more than one year.

#### EARLY RETIREES - FACULTY

- Tenured faculty members who retire on or after July 1 in the calendar year in which the faculty member reaches age 59 and before June 30 following reaching age 68, and who have at least 10 years of continuous eligible service, are eligible to participate in the health plan until the first of the month in which they turn 65.
- Adjunct faculty, Artists in Residence and Professors of the Practice who retire on or after age 55 and whose years of service and age total at least 75 are eligible to participate in the health plan until the first of the month in which they turn 65

#### EARLY RETIREES - STAFF

- Staff members who retire on or after age 55 and whose number of years of service and age total at least 75 may continue to participate in the health plan until the 1st of the month in which they turn age 65.
- Staff members who were hired prior to July 1, 2001 and who retire between ages 60 and the 65 with at least 10 years of continuous eligible service may also continue to participate in health plan until the first of the month when they turn age 65.
- Early Retirement - Secretarial/Clerical Staff: Members of the secretarial/clerical bargaining unit who retire on or after age 55 and whose number of years of service and age total at least 75 may continue to participate in the health plan until the first of the month in which they turn age 65.

#### EARLY RETIREMENT PUBLIC SAFETY STAFF

- Public Safety retirees who retire on or after age 55 and whose number of years of service and age total at least 75 may continue to participate in the health plan until the first of the month in which they turn age 65.
- Full-time employees who were hired prior to July 1, 2001 and who retire between ages 60 and 65 with at least ten years of continuous service may also continue to participate in the health plan until the first of the month in which they turn age 65 even though their number of years of service and age do not equal 75.

#### EARLY RETIREMENT PHYSICAL PLANT STAFF

The University will continue group insurance coverage for Physical Plant bargaining unit members who retire at age 60 or older with at least ten (10) years of service until the first of the month in which they reach age 65. Eligibility for this coverage will cease if the retiree undertakes employment elsewhere in which he or she is eligible for insurance coverage under the other employer's plan.

Early retirees will be billed for coverage on a monthly basis. Coverage will be cancelled if the premium is not paid according to the billing terms. If a retiree chooses to end coverage or coverage is cancelled due to non-payment prior to the periods allowed above, they cannot choose to re-enter the plan later. Early retirees' dependents & spousal/domestic partner coverage: If covered at the time of the member's retirement, the non-spouse/non-domestic partner dependents of an early retiree can be covered until the end of the month in which they turn 26 or the first of the month in which the retiree (or the spouse/domestic partner if they are covered longer than the retiree) turns 65, whichever is earlier. If the dependent is fully disabled, coverage ends the first of the month in which the retiree (or their spouse/domestic partner if they are covered longer than the retiree) turns 65 or until the dependent is no longer fully disabled, whichever occurs first. If covered by the plan at the time of the member's retirement, the spouse/domestic partner can continue coverage until Medicare eligible. If the spouse/domestic partner is Medicare-eligible at the time of the member's retirement, they are not eligible to continue coverage. If a dependent chooses to end coverage or coverage is cancelled due to non-payment prior to the periods allowed above, they cannot choose to re-enter the plan later.

For ACA employees, those who meet the ACA eligibility look back criteria are eligible to enroll for the following policy plan year.

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.

Coverage is effective on the date of hire for new employees and on the date of a status change for employees moving into a benefits-eligible position. Your election must be made within 31 days of your eligibility date and you are responsible for premiums retroactive to the eligibility date.

**Dependent Insurance**

If you are newly eligible and you have elected to cover your dependent(s), your dependent(s) are covered on your eligibility date. You may not cover your dependents without covering yourself. The only exception to this is covered dependents of a retiree turning age 65 may be covered until the first of the month in which they turn 65 or the case of a dependent child until the spouse or domestic partner turns 65, or the dependent turns age 26, whichever comes first. If you are adding coverage for your dependent(s) due to a life status event, you must make your election to cover the dependent(s) within 31 days of the qualifying life event and you are responsible for premiums retroactive to the qualifying life event.

**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.



### **Cigna Vision Providers**

To find a Cigna Vision Provider, or to get a claim form, the Insured Person should visit **myCigna.com** and use the link on the vision coverage page, or they may call Customer Service using the toll-free number on their identification card.

### **Reimbursement/Filing a Claim**

When an Insured Person(s) has an exam or purchases Materials from a Cigna Vision Provider they pay any applicable Copayment, Coinsurance or Deductible shown in The Schedule at the time of purchase. The Insured Person does not need to file a claim form.

If an Insured Person(s) has their exam or purchases Materials from a provider who is not a Cigna Vision Provider, the Insured Person pays the full cost at the time of purchase. The Insured Person must submit a claim form to be reimbursed. Send a completed Cigna Vision claim form and itemized receipt to:

Cigna Vision  
Claims Department  
P.O. Box 385018  
Birmingham, AL 35238-5018

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

<b>Cigna Vision</b>		
<b>The Schedule</b>		
<b>For You and Your Dependents</b>		
BENEFIT HIGHLIGHTS	IN-NETWORK **	OUT-OF-NETWORK
	The Plan will pay 100%	The plan will reimburse you at 100%, subject to any maximum shown below
<b>Examinations</b> One Eye Exam every Calendar Year	100%	\$75
<b>Eye Glasses/Contact Lenses/Frames</b>	Not Covered	Not Covered
**coverage may vary at participating discount retail and membership club optical locations, please contact Customer Service for specific coverage information.		

## Vision Benefits\*\*

Please be aware that the Vision network is different from the network of your medical benefits.

### For You and Your Dependents

#### Covered Expenses

##### Benefits Include:

Examinations – One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses.

\*\*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, or which is work-related.
- Claims submitted and received in excess of 12 months from the original date of service.

Other Limitations are shown in the **Exclusions, Expenses Not Covered and General Limitations** section.

HC-VISS5

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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 example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- 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.

HC-EXC1

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## Payment of Benefits

### Assignment and Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for plan benefits, to request plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

You may, however, authorize Cigna to pay any healthcare benefits under this policy to a provider. When you authorize the payment of your healthcare benefits to a provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Expenses directly to a provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you 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. In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

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## 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.
- If the employee terminates or changes to an ineligible status between the 1st to the 15th of the month, coverage terminates on the 15th. If the employee terminates or changes to an ineligible status the 16th to last day of the month, coverage ends on the last day of the month. ACA regulations are honored for those employees who are ACA eligible upon reduction of hours and rehire.

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

### Temporary Layoff or Leave of Absence

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 cancels your insurance. If you are under age 65 at the time of your total and continuous disability, you will be covered until age 65 if you remain totally and continuously disabled. If you are over age 65 at the time of your total and

continuous disability, you will be covered until your approved leave of absence ends and your employment is terminated. Required contributions must be made in order to continue coverage.

### **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 cancels your insurance.

### **Retirement**

If your Active Service ends because you retire (and meet the early retirement guidelines as determined by the employer), and you are under age 65 your insurance will be continued until the earlier of the date on which your Employer cancels your insurance; or your 65th birthday.

### **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.

If coverage is ceasing because a Dependent is turning age 26, that Dependent is covered until the end of the month in which that Dependent turns 26.

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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.

HC-FED1

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## **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

### 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.

HC-FED93 10-17

### Claim Determination Procedures under ERISA

**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-FED104

01-19

### **Appointment of Authorized Representative**

You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However, Cigna may require you to designate your authorized representative in writing using a form approved by Cigna. At all times, the appointment of an authorized representative is revocable by you. To ensure that a prior appointment remains valid, Cigna may require you to re-appoint your authorized representative, from time to time.

Cigna reserves the right to refuse to honor the appointment of a representative if Cigna reasonably determines that:

- the signature on an authorized representative form may not be yours, or
- the authorized representative may not have disclosed to you all of the relevant facts and circumstances relating to the overpayment or underpayment of any claim, including, for example, that the billing practices of the provider of medical services may have jeopardized your coverage through the waiver of the cost-sharing amounts that you are required to pay under your plan.

If your designation of an authorized representative is revoked, or Cigna does not honor your designation, you may appoint a new authorized representative at any time, in writing, using a form approved by Cigna.

HC-FED88

01-17

### **Medical - 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 representative or provider designated by you to act on your behalf, unless otherwise noted.

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 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 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**

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal of an adverse benefit determination, you must submit a request for an appeal in writing to Cigna 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.

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 Cigna to register your appeal by telephone. Call or write us at the toll-free 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 preservice or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your health care provider would cause you severe pain which cannot be managed without the requested services.

Cigna’s reviewer, in consultation with the treating health care provider, will decide if an expedited appeal is necessary.



When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

### **Level-Two Appeal**

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

Requests for a level-two appeal regarding the Medical Necessity or clinical appropriateness of your issue will be conducted by a Committee, which consists of one or more people not previously involved in the prior decision. The Committee will consult with at least one health care provider in the same or similar specialty as the care under consideration, as determined by Cigna's reviewer. You may present your situation to the Committee in person or by conference call.

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, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your health care provider, would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's reviewer, in consultation with the treating health care provider, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna 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 Cigna'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. Cigna 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 Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level-two appeal review denial. Cigna 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 Cigna's reviewer, the review shall be completed within 3 days. The Independent Review Program is a voluntary program arranged by Cigna.

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

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

### **Relevant Information**

Relevant Information is any document, record or other information which: 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 for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

### **Legal Action**

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna 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. However, no action will be brought at all unless brought within three years after proof of claim is required under the Plan.

HC-FED108

01-21

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

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

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

Under federal law, 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. 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. Your Dependents cannot change coverage options until the next open enrollment period.

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

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:

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).

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

If you retire and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before retirement, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare.

### **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).

### **Moving Out of Employer's Service Area or Elimination of a Service Area**

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.

## Employer's Notification Requirements

Your former 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 or your Dependents must notify the Plan Administrator of the 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 Dependents will lose the right to elect COBRA continuation coverage. If COBRA continuation coverage is rejected before the due date, your Dependents may change their mind as long as they 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..

## How Much Does COBRA Continuation Coverage Cost?

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

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

## When and How to Pay COBRA Premiums

### *First payment for COBRA continuation*

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

### *Subsequent payments*

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

### *Grace periods for subsequent payments*

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

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

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

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

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

### **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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### **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 Group Ins.  
237 High Street, 4th floor  
Middletown, CT 06459  
860-685-2100

Employer Identification Number (EIN):

060646959

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 service of legal process is:

Employer named above

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

The Cigna Claim Office responsible for this Plan

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

The Plan's fiscal year ends on 12/31.

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, which includes name, title and address, is available upon request to the Plan Administrator.

### **Plan Type**

The plan is a healthcare 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.

### **Discretionary Authority**

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

### **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 eligibility of classes of employees 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. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section);
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

### **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:

#### **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 a 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, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

### **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 your 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.

### **Enforce Your Rights**

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan 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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05-15

## 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.

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12-17

### Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, unmarried, 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 may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to time, but not

more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent provided they meet the requirements for children outlined above.

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

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

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01-17

### Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than sixth month;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or

- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

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### Employee

The term Employee means a retired employee.

HC-DFS1094 M 12-17

### Employer

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

HC-DFS8 04-10  
V1

### Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10  
V1

### 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  
V1

### 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-DFS1486 01-21

### Medicare

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

HC-DFS17 04-10  
V1

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**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  
V1

**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  
V1

**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

**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