Westwood Independent School District

CIGNA VISION INSURANCE

EFFECTIVE DATE: September 1, 2025

CN003
3346952

This document printed in July, 2025 takes the place of any documents previously issued to You which described Your benefits.

Printed in U.S.A.

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Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter referred to as "Cigna", "We", "Us", or "Our") certifies that it insures certain Employees for the benefits provided by the following Policy(ies):

POLICYHOLDER: Westwood Independent School District

GROUP POLICY(S) — CIGNA VISION PREFERRED PROVIDER INSURANCE
3346952 - VIS CIGNA VISION INSURANCE

EFFECTIVE DATE: September 1, 2025

This Certificate describes the main features of the insurance. It does not waive or alter any of the terms of the Policy(ies). If questions arise, the Policy(ies) will govern. This Certificate takes the place of any other issued to You on a prior date which described the insurance.

Alicia M. Morrow, ESQ, Corporate Secretary

Explanation of Terms

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

The Schedule

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

Important Notices

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 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. 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 전화해주십시오.

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 TTY 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 ناشنوایان: 800.428.4833).

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Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Cigna

To get information or file a complaint with your insurance company:

Call toll-free: 1-800-244-6224
Online: www.cigna.com
Mail: P.O. Box 188047
Chattanooga, TN 37422

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Cigna

Para obtener información o para presentar una queja ante su compañía de seguros:

Teléfono gratuito: 1-800-244-6224
En línea: www.cigna.com
Dirección postal: P.O. Box 188047
Chattanooga, TN 37422

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

How to Find a Cigna Vision Provider and File a Claim

Cigna Vision Providers

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

How to File a Claim

Reimbursement/Filing a Claim

When You have an exam or purchase Vision Materials from a Cigna Vision Provider You pay any applicable Copayment, Coinsurance or Deductible shown in The Schedule at the time of purchase. You do not need to file a claim form. There is no paperwork to submit for Covered Vision Services received from a Participating Provider.

If You have an exam or purchase Vision Materials from a provider who is not a Cigna Vision Provider, You pay the full cost at the time of purchase. You must submit a claim form to be reimbursed or the claim can be submitted by the provider if the provider is able and willing to file on Your behalf.

If Your plan provides coverage when care is received only from a Participating Provider, You may still have claims for services received from a Non-Participating Provider. For example, when Emergency Services are received from a Non-Participating Provider, You should follow the claim submission instructions for those claims. 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 below.

Send a completed Cigna Vision claim form and itemized receipt to:

Cigna Vision, Claims Dept. c/o FAA
PO Box 8504
Mason, OH 45040-7111

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

You may get the required claim forms from the website listed on Your identification card, if You received one, or by calling Customer Services using the toll-free number listed below.

Cigna's Toll-Free Number(s):

1-(800) CIGNA 24 (1-800-244-6224) or

1-(888)-353-2653

Claim Reminders

BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CLAIM FORMS, OR WHEN YOU CALL OUR 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 US.

Timely Filing of Claims

We will consider claims for coverage under Your plan when proof of loss (a claim) is submitted to Us within:

- 12 months for In-Network claims
- 12 months for Out-of-Network claims

after services are rendered. If services are rendered on consecutive days, the limit will be counted from the last date of service. If claims are not submitted to Us within the timeframe shown above, the claim will not be considered valid and will be denied. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

NOTE: We consider one month to equal 30 days regardless of the number of days within a calendar month.

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, may be guilty of committing a fraudulent insurance act determined by a court of law.

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Eligibility - Effective Date

Eligible Class

Each Employee as reported to Us by Your Employer.

Eligibility for Vision Insurance

You will become eligible for insurance on the day You complete the Eligibility Waiting Period, if any, and:

- You are an eligible Employee as determined by Your Employer.

Eligibility Waiting Period

Initial Group:

You are in the Initial Group of Employees if You are:

- employed in a class of Employees on the date that class of Employees becomes an Eligible Class as determined by Your Employer.

Your Eligibility Waiting Period is:

- A period of time as determined by Your Employer.

New Group:

You are in a New Group if You are:

- not in the Initial Group, or
- Your employment with an Employer starts after the Effective Date of that Employer's Policy.
- You were previously insured and Your insurance ceased, and You seek to become insured again.

Your Eligibility Waiting Period is:

- A period of time as determined by Your Employer.

Effective Date of Your Insurance

You will become insured on:

- the date that:

  You are in Active Service and You elect the insurance by:

  - authorizing premium payment,
  - approving a payroll deduction, or
  - signing an enrollment form, as applicable,

  but no earlier than the date You become eligible.

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

Dependent Insurance

For Your Dependents to be insured under the Policy, You must elect the Dependent Insurance for Yourself no later than 30 days after You become eligible. For Your Dependents to be insured, You will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Eligibility for Dependent Insurance

Your Dependent will become eligible for Dependent Insurance on the later of:

- the day You meet the eligibility requirements noted above; or
- the day You acquire Your first Dependent.

Effective Date of Dependent Insurance

Insurance for Your Dependents will become effective on the date You elect it, by signing a written agreement with the Employer to make the required contribution, 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.

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 coverage, 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 vision coverage ceases when the placement ends, and will not be continued. The provisions in the Exception for Newborns provision 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.

Exception for Newborns

Any Dependent child born while You are insured will become insured on the date of the child's birth if You elect Dependent Insurance no later than 31 days after birth. If You do not elect to insure Your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Dual Eligibility

If both You and Your Spouse are in an Eligible Class of the Employer, You may each enroll individually or as a Dependent of the other, but not as both. Any eligible Dependent child may also be enrolled by either You or Your Spouse. If the Spouse who enrolls for Dependent coverage ceases to be eligible, notify Your Plan Administrator immediately for coverage to continue under the plan of the other Spouse.

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Cigna Vision

The Schedule

For You and Your Dependents
Allowance The maximum amount Cigna will pay each Covered Person per Contract Year, the member is responsible for any amount over the allowance.
Copayments Copayments are amounts to be paid by you or your Dependent for covered services.
Contract Year Contract Year means a twelve month period beginning on each 09/01.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
BENEFIT HIGHLIGHTS	The Plan will pay 100% after any Copayment or Coinsurance, subject to any maximum Allowance shown below	The Plan will reimburse you at 100%, subject to any maximum Allowance shown below
EXAMINATION(S):		
Comprehensive Examination One Eye Exam every Contract Year	$10 Copayment	$45

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
VISION MATERIALS:		
Eyeglass Lenses One pair per Contract Year	$25 Copayment	
One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms). Including: Clear or sun lenses. Polycarbonate Eyeglass Lenses for children under 19 years of age. Oversized Eyeglass Lenses. Rose #1 & 2 solid tints.		
Single Vision Lenses	100% after Eyeglass Lens Copayment	$32
Lined Bifocal Lenses	100% after Eyeglass Lens Copayment	$55
Lined Trifocal Lenses	100% after Eyeglass Lens Copayment	$65
Lenticular Lenses	100% after Eyeglass Lens Copayment	$80
Contact Lenses and Professional Services (in lieu of eyeglass lenses and frames, in same frequency period) (may not receive eyeglass lenses, contact lenses and frames in the same frequency period) One pair of Elective conventional contact lenses or a single purchase of a supply of disposable contact lenses, One pair per Contract Year		
Elective	100% up to $130	$105
Therapeutic	100%	$210
Frames One pair per Contract Year	100% up to $130	$71

Covered Vision Expenses

Vision Benefits**

Please be aware that the Vision network is different from the network of your medical and/or dental benefits.

Covered Expenses

For You and Your Dependents

Benefits Include:

Examination(s)

Comprehensive Examination - One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses.

Materials

Vision Materials Coverage

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

- Clear or sun lenses.
- Polycarbonate lenses for children under 19 years of age.
- Oversize eyeglass lenses.
- Rose #1 and #2 solid tints.
- Coverage for One of the following eyeglass lens types:
  - Single Vision Eyeglass Lenses (pair)
  - Lined Bifocal Eyeglass Lenses (pair)
  - Lined Trifocal Eyeglass Lenses (pair)
  - Lenticular Eyeglass Lenses (pair)
  - Progressive lenses covered up to bifocal lens amount.
- Spectacle Lens treatments, “add ons”, or lens coatings:

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

Contact Lenses and Professional Services – One pair or a single purchase of a supply of contact lenses in lieu of eyeglass lenses and frame benefit (may not receive eyeglass lenses, contact lenses and frames in same benefit year). Contact lens retail allowance can be applied towards contact lens materials as well as the cost of supplemental contact lens professional services including fitting and evaluation, up to the stated allowance.

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

OTHER OPTIONAL VISION BENEFITS:

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

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Exclusions:

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

- Orthoptic or vision training and any associated supplemental testing.
- Medical or surgical treatment, services or supplies for the treatment of the eyes or supporting structures.
- Refraction, when not provided as part of a Comprehensive Eye Examination.
- 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.
- Services rendered after the date a Covered Person ceases to be covered under the Policy, except when Vision Materials are ordered before coverage ended and are delivered within 31 days from date of such order.
- 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 date the proof is otherwise required, unless the claimant does not have legal capacity.
- Electronic vision devices.
- Magnification or low vision aids.
- Spectacle lens treatments, “add-ons”, or lens coatings not shown as covered in The Schedule.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Prescription sunglass 'add-ons' or lens coatings not shown as covered in The Schedule.
- Any non-prescription (minimum RX required) eyeglasses, lenses, or contact lenses.
- Safety glasses or lenses required for employment.
- Solutions, cleaning products or frame cases.
- Lost, stolen or broken lenses, frames, glasses, or contact lenses that are replaced before the next benefit frequency when Vision Materials would next become available.
- For cosmetic contact lenses that do not improve vision.

Should any law require coverage for any particular service(s) noted above, the exclusion or limitation for that service(s) shall not apply.

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Coordination of Benefits

This section applies if You or any one of Your Dependents 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. Any other health coverage plans for You or any of Your covered Dependents are taken into account when benefits are paid.

Coverage under this Plan plus another Plan will not guarantee 100% reimbursement.

Definitions

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

A. **Plan.** A Plan is any of the following that provides benefits or services for medical, dental or vision care or treatment. Plan includes group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or non-group type coverage (whether insured or uninsured); and medical, dental or vision benefits under group or individual automobile contracts; Medicare, Medicaid or any other federal governmental plan, as permitted by law.

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

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

C. **Primary Plan.** The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan. A Plan that does not contain a coordination of benefits provision that is consistent with this section is always primary.

D. **Secondary Plan.** A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to You.

E. **Allowable Expenses.** The amount of charges considered for payment under the Plan for a Covered Vision Service prior to any reductions due to Coinsurance, Copayment or Deductible amounts. If We contract with an entity to arrange for the provision of Covered Vision Services through that entity’s contracted network of health care providers, the amount that We have agreed to pay that entity is the allowable amount used to determine Your Coinsurance, Copayment or Deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

   - An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
   - If You are 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 You are covered by one Plan that provides services or supplies on the basis of Reasonable and Customary

fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

- If Your benefits are reduced under the Primary Plan (through the imposition of a higher Copayment amount, higher Coinsurance percentage, a Deductible, and/or a penalty) because You did not comply with Plan provisions or because You did not use a Participating Provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of services.

F. **Custodial Parent.** The parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the Calendar Year, excluding any temporary visitation.

Order of Benefit Determination Rules

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

- **Employee:** The Plan that covers a person as an Employee shall be the Primary Plan and the Plan that covers a person as a Dependent shall be the Secondary Plan.
- Dependent: For a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the Calendar Year.
- For the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the Spouse of the parent with custody of the child;
  - then, the Plan of the noncustodial parent of the child, and
  - finally, the Plan of the Spouse of the parent not having custody of the child.
- **Employee in Active Service or laid-off Employee:** The Plan that covers You as an Employee in Active Service and Your Dependent shall be the Primary Plan and the Plan that covers You as a laid-off Employee and Your Dependent shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- **COBRA or State Continuation of Coverage**: The Plan that covers You under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers You as an Employee in Active Service or Your Dependent, shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers You is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.
- **Longer or Shorter Length of Coverage:** The Plan that covers a person for a longer period of time is the Primary Plan and the Plan that covered the person for the shorter period of time is the Secondary Plan.

If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between each of the Plans meeting the definition of a Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

Coordination for medical eye care or vision services. If a person is covered by at least 2 different health benefit plans or vision benefit plans, and the plans have the same coverage for the same vision or medical eye care services or products, the Primary Plan as determined by the COB applicable to the plan is responsible for the eye care expenses up to the full amount of any plan coverage limit that is applicable. Before the limit is reached, the Secondary Plan is responsible for eye care expenses covered under the plan that are not covered under the Primary Plan. After the limit has been reached under the Primary Plan, the Secondary Plan is responsible for any expenses covered by both plans that exceed the coverage limit, up to the limit of the Secondary Plan. A person may use each plan on the same date of service, up to the coverage limit of each plan. A vision plan issuer must coordinate benefits with a health benefit plan issuer if both provide benefits for eye care. Vision benefit plans cannot require a claim denial before adjudicating a claim up to the coverage limit of the plan. Secondary Plans are not prohibited from requiring proof that

the claim has been submitted to the Primary Plan to determine the remaining balance, however, the mechanism of providing this proof must be through an online submission.

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 are not more than 100% of the total of all Allowable Expenses.

Recovery of Excess Benefits

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

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

Right to Receive and Release Information

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

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Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by You or Your Dependent(s) for which another party may be responsible as a result of having caused or contributed to an injury or sickness.
- Expenses incurred by You or Your Dependent(s) to the extent any payment is received 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. The coverage under this plan is secondary to any automobile no-fault or similar coverage.

Right of Reimbursement

If a Covered Person incurs expenses for Covered Vision Services for which another party may be responsible or for which the Covered Person may receive payment as described above, We will be granted a right of reimbursement, to the extent of the benefits provided by Us, from the proceeds of any recovery whether by settlement, judgment, or otherwise.

Lien of the Plan

By accepting benefits under this plan, a Covered Person:

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

Additional Terms

- No adult Covered Person may assign any rights that the Covered Person may have to recover vision expenses from any third party or other person or entity to any Dependent child without Our prior express written consent. Our right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Covered Person shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- Our right of recovery shall be a prior lien against any proceeds recovered by the Covered Person. 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 Our recovery rights by allocating the proceeds exclusively to non-vision expense damages.

- No Covered Person shall incur any expenses on behalf of the plan in pursuit of the plan’s rights. Specifically; no court costs, attorneys' fees, or other representatives' fees may be deducted from the plan’s recovery without Our prior express written consent. This right shall not be defeated by any so-called “Fund Doctrine”, “Common Fund Doctrine”, or “Attorney’s Fund Doctrine”.
- We shall recover the full amount of benefits provided under the plan without regard to any claim of fault on the part of any Covered Person, whether under comparative negligence or otherwise.
- We hereby disavow all equitable defenses in the pursuit of Our right of recovery. Our recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Covered Person fails or refuses to honor his obligations under the plan. We shall be entitled to recover any costs incurred in enforcing the terms of the Policy including, but not limited to, attorney’s fees, litigation, court costs, and other expenses. We shall also be entitled to offset the reimbursement obligation against any entitlement to future vision benefits under the Covered Person has fully complied with his reimbursement obligations, regardless of how those future vision 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 Covered Person agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, We 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.
- Covered Persons must assist Us in pursuing any recovery rights by providing requested information.

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 Us to pay any healthcare benefits under this Policy to a Participating or Non-Participating Provider. When You authorize the payment of Your healthcare benefits to a Participating or Non-Participating 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 Us, it is the provider’s responsibility to reimburse the overpayment to You. We may pay all healthcare benefits for Covered Vision Services directly to a Participating Provider without Your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or Non-Participating 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 Non-Participating Provider has been authorized by You, We may make payment of benefits to You. When benefits are paid to You, You or Your Dependents are responsible for reimbursing the Non-Participating Provider.

Initial Determination

A claim for vision benefits will be reviewed upon receipt. We will notify You of Our decision to approve or deny the claim within 30 days from the date You submitted the claim, unless an extension is required due to matters beyond Our control. Any extension will not be more than 15 days.

If We require an extension, You will be notified in writing before the end of the initial 30 day period. The notice of extension will explain the reasons for the extension and will state when a determination will be made. If an extension is required because We require additional information from You, the time from the date of Our notice requesting further information and the time We receive the necessary information does not count toward the time period We are

allowed to notify You of the claim determination. You will have 45 days from the date You receive the request for additional information to provide the requested information.

Claim Denial

If Your claim is denied, in whole or in part, the notification of the claim decision will state the reason why Your claim was denied and reference the specific plan provisions upon which the denial is based. If the claim is denied because more information is needed from You, the claims decision will describe the additional information needed and why such information is needed. If We relied on an internal rule or other criterion when denying the claim, the claim decision will include the rule or other criteria or will indicate that such rule or criteria was relied upon and You may request a copy free of charge.

To Whom Payable

Vision benefit payments are assignable to the provider. When You assign benefit payments to a provider, You have assigned the entire amount of the payment due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of Our contracts with providers, all claims from contracted providers should be assigned.

We may, at Our option, make payment to You for the cost of any Covered Vision Services from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to You or Your Dependent(s), You or Your Dependent(s) are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or is not able to give a valid receipt for any payment due that person, such payment will be made to that person's legal guardian. If no request for payment has been made by that person's legal guardian, We will make payment to the person or institution appearing to have assumed that person's custody and support.

In the event of the death of a Covered Person, We may receive notice that an executor of the estate has been established. The executor has the same rights as the Covered Person and benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

When We have made an overpayment, We 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 Policy and/or assignment of benefits separately creates an equitable lien by agreement pursuant to which We may seek recovery of any overpayment. You agree that in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, We may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

HCVIS-POB1 01-24
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Termination of Insurance

Termination of Your Insurance

Your insurance will cease on the earliest date below:

- the date You cease to be in an Eligible Class 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 canceled or lapses due to a nonpayment of premium.
- the date as determined by Your Employer, except as described below.
- Your death.

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 temporary layoff or leave of absence, Your insurance will be continued until the date as determined by Your Employer.

Injury or Sickness

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

Termination of Insurance - Dependents

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

- the date Your insurance ceases; or

- the date You cease to be eligible for Dependent Insurance; or
- the last day for which You have made any required contribution for the insurance; or
- the date Dependent Insurance is canceled; or
- the date that Dependent no longer qualifies as a Dependent; or
- Your death.

Coverage for any Dependent child will terminate on the day the Dependent child turns age 26 Such termination will be without prejudice to any claim originating prior to the termination date. Our acceptance of any premium after such date will be considered as premium for only the remaining Covered Person(s) under the Policy.

However, coverage will continue for any Dependent child regardless of age, who is incapable of self-sustaining employment by reason of intellectual disabilities or a physical handicap. Proof of the child's condition and dependence may be required to be submitted to Us within 31 days after the date the child reaches the Dependent age limit.

HCVIS-TRM8 01-24
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Appointment of Authorized Representative

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

We reserve the right to refuse to honor the appointment of a representative if We reasonably determine 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 vision 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 We do not honor Your designation, You may appoint a new authorized representative at any time, in writing, using a form approved by Us.

HCVIS-AAR1 01-24

When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "You," "Your," or "Employee" also refers to a representative or provider designated by You to act on Your behalf; unless otherwise noted.

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

When You Have a Complaint

We are here to listen and help. If You have a 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 Customer Service representatives. You may also express that concern in writing.

Please call us at the Customer Service Toll-Free Number that appears on Your benefit identification card, explanation of benefits or claim form, or write to us at the following address:

Cigna
National Appeals Unit (NAO)
PO Box 188011
Chattanooga, TN 37422

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 send You a letter acknowledging the date on which We received Your complaint no later than the fifth working day after We receive Your complaint. We will respond in writing with a decision 30 calendar days after We receive a complaint for a post service coverage determination.

Internal Appeals Procedure

An Adverse Determination is a decision made by a utilization review agent that the service(s) furnished or proposed to be furnished to You is (are) not necessary or clinically appropriate, or are experimental or investigational. To initiate an appeal of a complaint resolution or Adverse Determination decision, You must submit a request for an appeal orally, or in writing to the following address:

Cigna
National Appeals Unit (NAO)
PO Box 188011
Chattanooga, TN 37422

You should state the reason why You feel Your appeal should be approved and include any information supporting Your appeal. If You are unable or choose not to write, You may ask Us 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.

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

We will respond in writing with a decision before the 30th calendar day after We receive an appeal for a post-service determination. We will respond before the 30th calendar day after We receive an appeal for any other post-service coverage determination.

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

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize Your life or health or would jeopardize Your ability to regain the functionality that existed prior to the onset of Your current condition.

A vision professional, in consultation with the treating Vision Provider, will decide if an expedited review is necessary. When a review is expedited, the Vision Plan will respond orally with a decision within 72 hours, but will not exceed one working day from the date all information necessary to complete the appeal is received, followed up in writing within three calendar days.

Independent External Review Procedure

If You are not fully satisfied with the decision of Our internal appeal review regarding Your clinical appropriateness issue, You may request that Your appeal be referred to a Texas independent review organization. The Texas independent review organization is composed of persons who are not employed by Us, or any of its affiliates. A decision to request a review by a Texas independent review organization will not affect the claimant's rights to any other benefits under the plan.

There is no charge for You to initiate an external review. We will abide by the decision of the Texas independent review organization.

In order to request a referral to a Texas independent review organization, the reason for the denial must be based on a clinical appropriateness determination by Us. 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 180-365 days of Your receipt of Our appeal review denial. We will then forward the file to the Texas independent review organization. The Texas independent review organization will render an opinion.

Appeal to the State of Texas

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

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

Notice of Benefit Determination on Appeal

Every notice of 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 below; a statement describing any other available appeal review, if applicable and the claimant's right to bring an action under ERISA section

502(a), if applicable; 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 an 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 Us until You have completed the level-one and level-two appeal processes. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network services or within 3 years after proof of claim is required under the plan for Out-of-Network services.

Miscellaneous

Notice Regarding Provider Directory

You may obtain a listing of Participating Providers who participate in Our vision network without charge by visiting www.cigna.com; mycigna.com; or by calling the toll-free telephone number 1-(800) CIGNA24 (1-800-244-6224).

Impossibility of Performance

Neither Policyholder nor Cigna shall be liable to the other or be deemed to be in breach of this Contract for any failure or delay in performance arising out of unforeseeable events beyond the control of either party. Such events are limited to include natural disaster, war, riot, acts of terrorism (domestic and/or foreign), epidemic, pandemic, cyber events (including breakdown of communication facilities, web hosting and internet services) or any other emergency or similar event not within either party’s control which may result in facilities, personnel, or financial resources being unavailable to provide or arrange for the provision of services in accordance with this Policy. Timelines for performance shall be extended to the extent necessary and agreed upon by both parties, provided that the party whose performance is affected notifies the other promptly of the existence and nature of the delay and the impacted party makes good faith effort to provide or arrange for the provision of service, taking into account the severity of the event.

Administrative Policies Relating to this Contract

We may adopt reasonable policies, procedures, rules and interpretations that promote orderly administration of this Contract.

Assignability

The benefits under this Contract are not assignable unless agreed to by Us. We may, at Our option, make payment to the Employee for any cost of any Covered Vision Expense received by the Employee or Employee’s covered Dependents from a Non-Participating Provider. The Employee is responsible for reimbursing the Non-Participating Provider.

Clerical Error

No clerical error on the part of Us shall operate to defeat any of the rights, privileges or benefits of any Employee.

Entire Contract

The entire Contract will be made up of the Policy; the Certificate; the application of the Policyholder, a copy of which is attached to the Policy; any riders and amendments to the Policy or Certificate; and any enrollment forms.

Conformity with State and Federal Statutes

Any provision of this Certificate that is in conflict with the applicable statutes of the state whose law governs the Policy or this Certificate or with any applicable federal statute is amended to conform to the minimum requirements of such statutes.

Statements not Warranties

All statements made by the Policyholder or any person covered under the Certificate will, in the absence of fraud, be deemed representations and not warranties. No statement made by You or the Policyholder to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and signed by You or the Policyholder and a copy is sent to the Policyholder, You and/or Your beneficiary.

Time Limit on Certain Defenses

After two years from the Effective Date, no misstatements, except fraudulent misstatements, made by You in the application or any application amendment will be used to void this Certificate or to deny a claim for loss incurred after the expiration of such two-year period. No claim for loss commencing after 12 months from the Effective Date will be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

Your Vision Records

In order to provide benefits under this Certificate, process claims, make payments or review appeals and/or grievances, We may need to obtain information and records from the Vision Provider who provided Your services or treatment. Your acceptance of coverage under the Policy gives Us permission to obtain, copy and use Your vision records and information for such purposes and authorizes Your Vision Provider to disclose information that pertains to Your physical condition or the services or treatment You receive. We agree to maintain Your vision records and information in accordance with state and federal confidentiality requirements.

HCVIS-MISC7 01-24
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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 as determined by Your Employer 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.

HCVIS-DFS60 01-24
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Amount Eligible for Coverage by Your Plan

The term means, part of the “Amount Your Health Care Professional Charged” or “Your Health Care Professional’s Contracted Amount” (if present) that is eligible for coverage under Your plan. This amount is used to help calculate how much will be paid by Your plan.

HCVIS-DFS61 01-24

Balance Billing

When a Vision Provider bills an enrollee for amounts above the Amount Eligible for Coverage by Your Plan, the Vision Provider may bill You for the difference. Non-Participating Vision Providers are under no obligation to limit the amount of their fees.

HCVIS-DFS63 01-24

Certificate

The term Certificate means this document, including any riders and attachments hereto, which sets forth Your benefits under the plan.

HCVIS-DFS66 01-24

Coinsurance

The term Coinsurance means the percentage of charges for Covered Vision Expenses that a Covered Person is required to pay under the plan.

HCVIS-DFS68 01-24

Contract

The Contract will be made up of the Policy; the Certificate; the application of the Policyholder, a copy of which is attached to the Policy; any riders and amendments to the Policy or Certificate; and any enrollment forms.

HCVIS-DFS69 01-24

Contract Year

The term Contract Year means the twelve-month period beginning at 12:01 a.m. on the first day of the initial term or any renewal term and ending at 12:01 a.m. on the next anniversary of that date.

HCVIS-DFS70 01-24

Contract Year Maximum

This is the most We will pay for vision care within a Contract Year. Once You reach the maximum amount, You will be responsible for paying any costs for the remainder of the benefit period.

HCVIS-DFS65 01-24

Contracted Fee

The term Contracted Fee means the total compensation level that a provider has agreed to accept as payment for vision procedures and services performed on You or Your Dependent, according to Your vision benefit plan.

HCVIS-DFS71 01-24

Copayment

The term Copayment means a defined dollar amount a Covered Person is required to pay for certain vision services payable under the plan. The Covered Person is responsible for the payment of any Copayment directly to the provider of the vision service at the time of service or when billed by the provider.

HCVIS-DFS72 01-24

Covered Expenses

The term Covered Expenses means that portion of a Vision Provider's charge that is payable for a service delivered to a Covered Person provided:

- Provided by or under the direction of a Vision Provider or other appropriate provider as specifically described;
- Identified as payable in this Certificate;
- The maximum benefit in The Schedule has not been exceeded; and
- It is not excluded as described in the section entitled Exclusions and Limitations

HCVIS-DFS73 01-24

Covered Person

The term Covered Person means a person who is insured for vision coverage under the terms of the Policy and this Certificate.

HCVIS-DFS74 01-24

Dependent

The term Dependent means:

- Your lawful Spouse; 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 intellectual or physical disabilities. Proof of the child's condition and dependence may be required to be submitted to Us within 31 days after the date the child

ceases to qualify above. During the next two years We may, from time to time, require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.

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, or a child supported pursuant to a court order imposed on You (including a Qualified Medical Child Support Order) or Your grandchild who is Your Dependent for federal income tax purposes at the time of application.

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.

HCVIS-DFS151 01-24

Effective Date

The term Effective Date means the date that coverage for insurance begins under the Policy. See the Certificate cover page for the Effective Date.

HCVIS-DFS77 01-24

Eligibility Waiting Period

The term Eligibility Waiting Period means the period of time that an Employee must be in an Eligible Class in order to be eligible for coverage under the Policy.

HCVIS-DFS78 01-24

Eligible Class

The term Eligible Class means a group of people who are eligible to enroll for insurance coverage under the Policy as determined by the Employer.

HCVIS-DFS79 01-24

Eligible Employee

The term Eligible Employee means a person who is in Active Service with the Employer and who meets all the conditions to enroll for insurance under this plan as determined by the Employer.

HCVIS-DFS80 01-24

Eligible Person

The term Eligible Person means a person who meets the Employer's conditions for enrollment for insurance coverage under the Policy.

HCVIS-DFS82 01-24

Emergency Service

The term Emergency Service means a service required immediately to either alleviate pain or to treat the sudden onset of an acute vision condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious vision or medical complication.

HCVIS-DFS83 01-24

Employee

The term Employee means, an individual meeting the eligibility criteria determined by Your Employer and who is enrolled for vision coverage and for whom all required premiums have been received by Us. Also referred to as "You" or "Your".

HCVIS-DFS84 01-24

Employer

The term Employer means the Policyholder and all subsidiaries.

HCVIS-DFS86 01-24

Full-Time

The term Full-Time means the number of hours set by the Employer as a regular work-week for persons in an Eligible Class.

HCVIS-DFS88 01-24

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.

HCVIS-DFS94 01-24

Medicare

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

HCVIS-DFS95 01-24

Non-Participating Provider

The term Non-Participating Provider means a Vision Provider, or a professional corporation, professional association, partnership, or other entity that has not entered into a Contract with Us to provide vision services. Services received from Non-Participating Providers are considered out-of-network ("Out-of-Network").

HCVIS-DFS97 01-24

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.

HCVIS-DFS98 01-24

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.

HCVIS-DFS99 01-24

Optometrist

The term Optometrist means a person practicing optometry, including a therapeutic Optometrist, 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.

HCVIS-DFS159 01-24

Participating Provider

The term Participating Provider means: a Vision Provider, or a professional corporation, professional association, partnership, or other entity which is entered into a Contract with Us to provide vision services at predetermined fees.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by Your Employer. Services received from Participating Providers are considered in-network ("In-Network").

HCVIS-DFS102 01-24

Policy

The term Policy means a written agreement between the Policyholder and Us outlining the terms and conditions under which We agree to insure certain Employees and pay benefits.

HCVIS-DFS106 01-24

Policyholder

The term Policyholder means the owner of the group Policy as identified on the certification page.

HCVIS-DFS107 01-24

Qualified Medical Child Support Order

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 requirement above.

HCVIS-DFS108 01-24

Spouse

The term Spouse means Your legally recognized Spouse.

HCVIS-DFS158 01-24

Usual Fee

The fee that an individual Vision Provider most frequently charges for a given vision service.

HCVIS-DFS113 01-24

Vision Materials

The term Vision Materials means those materials provided for visual health and welfare shown in the Schedule of Benefits.

HCVIS-DFS114 01-24

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.

HCVIS-DFS115 01-24

We, Us and Our

The terms We, Us and Our mean Cigna Health and Life Insurance Company.

HCVIS-DFS116 01-24

You, Your, Yourself

The Employee and/or any of his/her Dependents.

HCVIS-DFS117 01-24

Federal Requirements

The following Federal Requirement section is not part of your group insurance certificate. 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 your group insurance

certificate, the provision which provides the better benefit will apply.

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Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

A list of network providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of vision practitioners, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

HC-FED78 01-24
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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

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage elections

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

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

B. Change of status

A change in status is defined as:

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

C. Court order

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

D. Medicare or Medicaid eligibility/entitlement

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

E. Change in cost of coverage

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

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

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

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

G. Reduction in work hours

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

H. Enrollment in a Qualified Health Plan (QHP)

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

Family: A plan may allow an Employee to revoke family coverage midyear in order for family members ("related individuals") to enroll in a QHP through an Exchange (Marketplace). The related individual(s) seek to enroll in a QHP during the Marketplace's annual open enrollment period, and the disenrollment from the group plan corresponds to the intended enrollment of the individual(s) in a QHP for new coverage effective beginning no later than the day immediately following the last day of the original coverage. If the Employee does not enroll in a QHP, the Employee must select self-only coverage or family coverage including one or more already-covered individuals.

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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.

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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

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

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

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

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

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

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

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

Reinstatement of Benefits (applicable to all coverages)

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

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

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

HC-FED18 10-10

Claim Determination Procedures

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.

You or your authorized representative (typically, your health care professional) 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 covered, 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 as applicable, and in the determination notices.

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.

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: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; 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, if applicable; 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, 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; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

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COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

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

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

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

Who is Entitled to COBRA Continuation?

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

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

Secondary Qualifying Events

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

Disability Extension

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

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

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

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

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

Medicare Extension for Your Dependents

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

Termination of COBRA Continuation

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

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

Employer's Notification Requirements

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

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

How to Elect COBRA Continuation Coverage

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

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

How Much Does COBRA Continuation Coverage Cost?

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

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

elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

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

Grace periods for subsequent payments

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

You Must Give Notice of Certain Qualifying Events

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

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

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

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

Newly Acquired Dependents

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

COBRA Continuation for Retirees Following Employer's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

Interaction With Other Continuation Benefits

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

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