

Community Action Team, Inc.

Vision PPO Scheduled

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INTRODUCTION

■ Notices

Discrimination is Against the Law

Cigna, in its role as benefits administrator, 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 Cigna, such as qualified sign language interpreters and 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 and information written in other languages.

If you need these services, contact Customer Service/Member Services at the toll-free phone number shown on your ID card, and ask an 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 toll-free phone number shown on 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 at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; or by phone at 1-800-368-1019, TDD 800-537-7697.

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

Proficiency of Language Assistance Services

ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1-800-244-6224 (TTY: Dial 711).

Spanish

ATENCIÓN: tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1-800-244-6224 (los usuarios de TTY deben llamar al 711).

Chinese

注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1-800-244-6224（聽障專線：請撥 711）。

Vietnamese

CHÚ Ý: Có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Dành cho khách hàng hiện tại của Cigna, gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1-800-244-6224 (TTY: Quay số 711).

Korean

주의: 언어 지원 서비스를 비용없이 이용하실 수 있습니다. 기존 Cigna 가입자의 경우, 가입자 ID 카드 뒷면에 있는 전화번호로 연락해 주십시오. 아니면 1-800-244-6224번으로 연락해 주십시오(TTY: 711 번으로 전화).

Tagalog

PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1-800-244-6224 (TTY: I-dial ang 711).

Russian

ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1-800-244-6224 (TTY: 711).

Arabic

برجاء الانتباه خدمات الترجمة المجانية متاحة لكم لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1-800-244-6224 (TTY: اتصل ب 711).

French Creole

ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1-800-244-6224 (TTY: Rele 711).

French

ATTENTION : des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1-800-244-6224 (ATS : composez le numéro 711).

Portuguese

ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1-800-244-6224 (Dispositivos TTY: marque 711).

Polish

UWAGA: W celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1-800-244-6224 (TTY: wybierz 711).

Japanese

お知らせ：無料の日本語サポートサービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号におかけ下さい。その他の方は、1-800-244-6224におかけください。（文字電話: 番号711）。

Italian

ATTENZIONE: sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera ID. In caso contrario, chiamare il numero 1-800-244-6224 (utenti TTY: chiamare il numero 711).

German

Achtung: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Für gegenwärtige Cigna-Kunden, Bitte rufen Sie die Nummer auf der Rückseite Ihres Personalausweises. Sonst, rufen Sie 1-800-244-6224 (TTY: Wählen Sie 711).

Farsi

توجه: خدمات کمکی زبان، رایگان در دسترس شما است. برای مشتریان فعلی Cigna، لطفاً با شماره ای که در پشت کارت شناسایی شما است تماس بگیرید. در غیر اینصورت، با شماره 1-800-244-6224 تماس بگیرید (TTY: 711 را شماره گیری کنید).

■ About This Plan

Community Action Team, Inc. (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). As of July 1, 2017, the vision benefits described in this booklet form a part of the Employee Welfare Benefit Plan and are referred to collectively in this booklet as the Plan. The Employee Welfare Benefit Plan will be maintained pursuant to the vision benefit terms described in this booklet. The Plan may be amended from time to time.

This booklet takes the place of any other issued to you on a prior date.

The vision benefits described in this booklet are self-funded by the Employer. The Employer is fully responsible for the self-funded benefits. Cigna Health and Life Insurance Company (Cigna) processes claims and provides other services to the Employer related to the self-funded benefits. Cigna does not insure or guarantee the self-funded benefits.

Defined terms are capitalized and have specific meaning with respect to vision benefits, see GLOSSARY.

Discretionary Authority

The Plan Administrator has the discretionary authority to control and manage the operation and administration of the Employer's self-funded vision benefit Plan. The Plan Administrator in his or her discretionary authority, will determine benefit eligibility under such self-funded Plan, construe the terms of the self-funded Plan and resolve any disputes which may arise with regard to the rights of any person under the terms of the self-funded Plan, including but not limited to eligibility for participation and claims for benefits.

For initial claim determination, the Plan Administrator has the discretionary authority to determine eligibility and to interpret the Plan. For claim appeals, the Plan Administrator has designated Cigna Health and Life Insurance Company as the appeals fiduciary. Cigna will have the discretionary authority to determine whether a claim should be paid or denied on appeal and according to the Plan provisions.

Plan Modification, Amendment and Termination

The Employer reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other Plan term or condition, and to terminate the whole Plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any Plan Member is required to terminate, modify, amend or change the Plan.

VISION BENEFITS SCHEDULE

This Schedule provides a general description of vision benefits. It does not list all benefits. The Plan contains limitations and restrictions that could reduce the benefits payable under the Plan. Please read the entire booklet for details about your benefits.

Examinations - 1 eye exam per calendar year

- Network Plan pays 100% after Member pays \$20.00
- Non-Network Plan pays 100% up to \$ 45.00

Lenses and Frames - When the provider is a network provider, the Member pays \$20.00

This copay does not apply to Contact Lenses.

Lenses - 1 pair per calendar year

- Single Vision Lenses
 - * Network Plan pays 100% after Member pays Lenses and Frames copay
 - * Non-network Plan pays up to \$32
- Bifocal Lenses
 - * Network Plan pays 100% after Member pays Lenses and Frames copay
 - * Non-network Plan pays up to \$55
- Trifocal Lenses
 - * Network Plan pays 100% after Member pays Lenses and Frames copay
 - * Non-network Plan pays up to \$65
- Lenticular Lenses
 - * Network Plan pays 100% after Member pays Lenses and Frames copay
 - * Non-network Plan pays up to \$80

Contact Lenses - 1 pair or a single purchase of a supply per calendar year

- Elective
 - * Network Plan pays 100% up to \$300.00
 - * Non-network Plan pays 100% up to \$192.00
- Therapeutic
 - * Network Plan pays 100%
 - * Non-network Plan pays 100% up to \$210.00

Frames - 1 pair per calendar year

- Network Plan pays 100% up to \$300.00 after Member pays Lenses and Frames copay
- Non-network Plan pays 100% up to \$130.00

ELIGIBILITY

■ Eligible Employees

For the purpose of vision benefits, an eligible Employee is a person who is in the Service of the Employer and is a resident of the United States.

Service

“Service” means work with the Employer on an active, full-time and full pay basis for at least 20.0 hours per week.

■ Eligible Dependents

If you and your spouse are eligible to be covered as Employees: A person who is eligible as an Employee will not be considered as an eligible Dependent. An eligible Dependent child may be considered as a Dependent of only one Employee.

If you are eligible to be covered as an Employee and as a Dependent child of another Employee: A person who is eligible as an Employee will not be considered as an eligible Dependent.

It is your responsibility to notify the Employer when a covered Dependent is no longer eligible for coverage.

Your Dependents must live in the United States to be eligible for coverage.

Eligible Dependents are:

- your legal spouse.
- a child under age 26.

Child

“Child” means:

- your natural child.
- your stepchild.
- your adopted child. This includes a child placed with you for adoption.

“Placed for adoption” means the assumption and retention of a legal obligation for the total or partial support of a child in anticipation of the adoption of such child. The child’s placement is considered terminated upon the termination of such legal obligation.

- a child who is recognized under a medical child support order as having a right to enrollment under the Plan.
- a foster child.

Handicapped/Disabled Child

The age limit does not apply to a child who becomes disabled, or became disabled, before reaching the age limit and who: cannot hold a self-supporting job due to a permanent physical handicap or intellectual disability; and depends on you for financial support.

“Physical handicap/intellectual disability” means permanent physical or mental impairment that is a result of either a congenital or acquired illness or injury leading to the individual being incapable of independent living.

“Permanent physical or mental impairment” means:

- a physiological condition, skeletal or motor deficit; or
- intellectual disabilities or organic brain syndrome.

A non-permanent total disability where medical improvement is possible is not considered to be a “handicap” for the purpose of this provision. This includes substance abuse and non-permanent mental impairments.

At reasonable intervals, but not more often than annually, the Plan may require a Doctor’s certificate as proof of the child’s disability.

ELIGIBILITY - Continued

Medical Child Support Order

A medical child support order is a *qualified* medical child support order (QMCSO) or a *qualified* national medical support notice issued by a state court or administrative agency that requires the Plan to cover a child of an Employee, if the Employee is eligible for benefits under the Plan.

When the Employer receives a medical support order, the Employer will determine whether the order is “qualified”.

If the order is determined to be qualified, and if you are eligible to receive benefits under this Plan, then your Dependent child will be covered, subject to any applicable contribution requirements. Your Employer will provide your Dependent child with necessary information which includes, but is not limited to, a description of coverages and ID cards, if any. Upon request, your Employer will provide at no charge, a description of procedures governing medical child support orders.

WHEN COVERAGE BEGINS & ENDS

■ When Will Coverage Begin?

The definition of Employee or Dependent in ELIGIBILITY will determine who is eligible for coverage under the Plan.

Coverage will begin on the first day of the month coinciding with or next following the date you satisfy any eligibility waiting periods required by the Employer, if you meet the Service definition in ELIGIBILITY on that day, or if due to your health status you do not meet the Service definition on that day.

Before coverage can start, you must:

- Submit an application within 31 days after becoming eligible;
- Pay any required contribution.

Coverage for a newly acquired Dependent will begin on the date you acquire the Dependent if you are covered and if you apply for coverage within 31 days after acquiring the new Dependent.

If the Dependent is an adoptive child, coverage will start:

- For an adoptive newborn, from the moment of birth if the child's date of placement is within 31 days after the birth; and
- For any other adoptive child, from the date of placement.

■ What If I Don't Apply On Time?

You are a late applicant under the Plan if you don't apply for coverage within 31 days of the date you become eligible for coverage.

Your Dependent is a late applicant if you elect not to cover a Dependent and then later want coverage for that Dependent.

A late applicant may apply for coverage only during an open enrollment period. The Plan Administrator can tell you when the open enrollment period begins and ends. Coverage for a late applicant who applies during the open enrollment period will begin on the first day of the month following the close of the open enrollment period.

Your eligible Dependent is not a late applicant if you did not apply to cover the Dependent within 31 days of the date you became eligible to do so and later are required by a qualified court order to provide coverage under this Plan for that Dependent. If you apply within 31 days of the date the court order is issued, coverage will start on the court ordered date.

■ Will My Coverage Change?

If the Employer amends the benefits or amounts provided under the Plan, a Member's coverage will change on the effective date of the amendment. If a Member changes classes, coverage will begin under the new class the first day of the month coinciding with or next following the date the Member's class status changes.

All claims will be based on the benefits in effect on the date the claim was incurred.

■ When Will My Coverage End?

Your coverage will end on the earliest of the following dates:

- The date the Employer terminates the benefits described in this booklet.
- The last day of the calendar month in which your Service ends.
- The date you are no longer eligible for reasons other than end of your Service.
- The due date of the first contribution toward your coverage that you or the Employer fails to make.

Your Dependent coverage will end on the earliest of the following dates:

- The date your coverage ends.
- The date you cease to be eligible for Dependent coverage.
- The date your Dependent ceases to be an eligible Dependent.

WHEN COVERAGE BEGINS & ENDS - Continued

For your covered Dependent child who reaches the limiting age (see ELIGIBILITY), this is the last day of the calendar month in which the limiting age is reached.

- The due date of the first contribution toward Dependent coverage that you or the Employer fails to make.

Continuation of Coverage under Federal Laws and Regulations

If coverage would otherwise terminate under this Plan, you and your Dependents may be eligible to continue coverage under certain federal laws and regulations. See USERRA RIGHTS AND RESPONSIBILITIES, CONTINUATION OF COVERAGE - FMLA and CONTINUATION OF COVERAGE - COBRA.

■ Can Coverage Be Reinstated?

If your coverage ended because of termination of your Service, you may be eligible for reinstatement of coverage if you return to Service within 3 months after the date your coverage ended.

On the date you return to Service, coverage for you and your eligible Dependents will be on the same basis as that provided for any other active Employee and his or her Dependents as of that date. However, any restrictions on your coverage that were in effect before your reinstatement will still apply.

See USERRA RIGHTS AND RESPONSIBILITIES for information about reinstatement of coverage upon return from leave for military service.

VISION BENEFITS

■ What's Covered? (Covered Expenses)

All providers, including any facilities, must be licensed in accordance with the laws of the appropriate legally authorized agency, and acting within the scope of such license.

Examinations

The Plan covers one vision and eye health evaluation, including but not limited to eye health examination, dilation, refraction and prescription for glasses.

Lenses (Glasses)

The Plan covers one pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms). This includes polycarbonate lenses for children under age 18; oversize lenses; rose #1 and #2 solid tints; and progressive lenses up to the bifocal lenses amount.

Frames

The Plan covers one frame up to the frame allowance shown in the VISION SCHEDULE.

Contact Lenses

The Plan covers one pair or a single purchase of a supply of contact lenses in lieu of the above glasses and frame benefit. The Plan does not cover contact lenses in the same benefit year as glasses and frames. The contact lens allowance may be applied to contact lens materials, as well as to the cost of supplemental contact lens professional services including fitting and evaluation, up to the contact lens allowance shown in the VISION SCHEDULE.

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

BENEFIT LIMITATIONS

General Limitations and Exclusions

No amount will be payable for:

- any charge not included as a covered expense under the Plan.
- charges which would not have been made if the Member did not have coverage.
- charges which the Member is not obligated to pay, or for which the Member is not billed or for which the Member would not have been billed except that they were covered under the Plan. For example, if Cigna determines that a provider is waiving, discounting, reducing, forgiving or has waived, discounted, reduced, or forgiven any portion of its charges and/or any portion of deductible, copay, coinsurance amount(s) you are required to pay for a Covered Expense without Cigna's express consent, then Cigna in its role as benefits administrator shall have the sole discretion to: (i) deny the payment of benefits in connection with the Covered Expense; or (ii) reduce the benefits in proportion to the amount of the deductible, copay or coinsurance amount(s) waived, discounted, forgiven or reduced; regardless of whether the provider represents that you remain responsible for any amounts that the Plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost-sharing payment(s) prior to the payment of any benefits under the Plan. This exclusion includes, but is not limited to, charges of a provider who is not a network provider who has agreed to charge you, or has charged you, based upon what you would be required to pay out-of-pocket for treatment provided by a network that provider or some other benefit level not otherwise applicable to the treatment received.
- charges arising out of, or relating to, any violation of a healthcare-related state or federal law, or which themselves are a violation of a healthcare-related state or federal law.
- treatment of an Injury or Sickness which is due to war, declared or undeclared, riot or insurrection.
- services, drugs and supplies that are not Medically Necessary.
- charges for or in connection with experimental or non-conventional procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.
- care for health conditions required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition.
- expenses for care provided through or by a public program, to the extent that a Member is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- expenses incurred outside the United States.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges made by a provider for broken appointments, phone calls, email or internet evaluations unless otherwise specified as covered under the Plan.
- court-ordered treatment, unless such treatment is prescribed and listed as covered in this Plan.
- vision care expenses for the infant child of a Dependent, unless the infant child is otherwise eligible under this Plan.

BENEFIT LIMITATIONS - Continued

Vision Benefit Limitations and Exclusions

No amount will be payable for:

- charges in excess of the usual and customary charge for the service or materials.
- medical or surgical treatment of the eyes.
- orthoptic or vision training and any associated supplemental testing.
- magnification or low vision aids.
- VDT (video display terminal) computer eyeglass benefit.
- any eye examination, or any corrective eyewear required by an employer as a condition of employment.
- safety glasses or lenses required for employment.
- lens treatments or “add-ons”, except as described in the Plan.
- two pairs of glasses, in lieu of bifocals or trifocals.
- high index lenses of any material type.
- prescription sunglasses.
- any non-prescription eyeglasses, lenses or contact lenses.
- charges incurred after the Plan terminates or after the Member’s coverage ends, except as stated in the Plan.

CLAIMS & LEGAL ACTION

■ How To File Claims

As used in this provision, any reference to “you” or “your” refers to the covered Member, and also refers to a representative or provider designated by you to act on your behalf.

A claim form can be requested from the Plan Administrator, through the website address or by calling Member Services at the phone number shown on your ID card. Complete and accurate claim information is necessary to avoid claim processing delays.

Timely Filing of Claims

Cigna will consider claims for coverage, other than Network coverage, under the Plan when proof of loss (a claim) is submitted within 180 days after expenses are incurred. If expenses are incurred on consecutive days, the limit will be counted from the last date expenses are incurred. If the claim is not submitted within the specified time period, it will not be considered valid and will be denied.

Vision Benefits

When using a network provider, you do not need to file a claim if you present your ID card. The network provider will file the claim. When using non-network providers, claims can be submitted by the provider if the provider is willing and able to file on your behalf. If the provider is not submitting on your behalf, you must send the completed claim form and itemized bills to the address shown on the claim form.

■ Claim Determinations and Appeal Procedures

As used in this provision, any reference to “you” or “your” refers to the covered Member, and also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

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.

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 this Plan booklet, in the provider’s network participation documents as applicable, and in the determination notices.

Post-Service Determinations

When you or your representative requests a coverage determination or claim payment determination after care has been provided, 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 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.

CLAIMS & LEGAL ACTION - Continued

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 apply 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 applicable time limits, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) 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 Medical Necessity, experimental treatment or other similar exclusion or limit; in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

COMPLAINTS and APPEALS - Cigna has a process for addressing your concerns.

Start with Customer Service

If you have a concern regarding a person, a service, the quality of care, contractual benefits you may call Customer Service at the phone number shown on your ID card, explanation of benefits or claim form and explain your concern to a Customer Service representative. You may also express that concern in writing.

Customer Service will make every effort to resolve the matter on your initial contact. If more time is needed to review or investigate your concern, a response will be provided to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Internal Appeals Procedure

To initiate an appeal you must submit a request for an appeal in writing to Cigna within 180 days of the date the notice of denial is received. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call Customer Service at the phone number shown on your ID 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 Medical Necessity or clinical appropriateness will be considered by a health care professional.

Cigna will respond within 60 calendar days after receipt of an appeal for a postservice coverage determination. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

External Review Procedure

If you are not fully satisfied with the decision of Cigna's internal appeal review regarding your clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by Cigna or any of its affiliates. A decision to request an external review to an IRO 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. Cigna and your benefit plan will abide by the decision of the IRO.

To request a review, you must notify Cigna's Appeals Coordinator within 4 months of receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render a decision within 45 days.

CLAIMS & LEGAL ACTION - Continued

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 voluntary appeal procedures offered by the Plan and the claimant's right to bring a civil 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 was based on Medical Necessity, experimental treatment or other similar exclusion or limit.

"Relevant Information" means any document, record or other information that: 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; 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 ERISA Section 502(a) if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the appeal processes, as applicable. Legal action must be taken for network expenses within 3 years after a claim is submitted, and for expenses other than network expenses within 3 years after proof of claim is required under the Plan.

■ What If a Member Has Other Coverage? (Coordination of Benefits)

This Coordination of Benefits provision applies if you or any one of your Dependents is covered under more than one Plan, and determines how benefits payable from all Plans will be coordinated. Claims should be filed with each Plan.

As used in this provision, references to "you" or "your" refers to each covered Member.

Under this provision, total payments from the Primary and Secondary Plans will never be more than the expenses actually incurred.

Definitions

For the purpose of this provision, the following terms have the meanings described here:

- "Plan" means any of the following that provides health care benefits, services or treatment:
 - this Plan.
 - group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including Closed Panel coverage.
 - coverage under Medicare and other governmental benefits as permitted by law, except Medicaid and Medicare supplement policies.
 - health care benefits coverage of group, group-type and individual automobile contracts.

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

- "Closed Panel Plan" means a Plan that provides health care benefits primarily in the form of services or supplies through a panel of employed or contracted providers, and that limits or excludes benefits provided outside of the panel, except in the case of emergency or if referred by a provider within the panel.
- "Primary Plan" means the Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

CLAIMS & LEGAL ACTION - Continued

- “Secondary Plan” means 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.
- “Allowable Expense” means a necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
 - If 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 is the Allowable Expense.
 - If your benefits are reduced under the Primary Plan (through imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.
- “Claim Determination Period” means a calendar year, but does not include any part of a year during which you are not covered under this Plan or any date before this provision or any similar provision takes effect.
 - “Reasonable Cash Value” means an amount which a duly licensed provider of health care services or supplies usually charges patients and which is within the range of fees usually charged for the same service or supply by other health care providers located within the immediate geographic area where the health care service or supply is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this provision will always be the Primary Plan.

If the Plan has a coordination of benefits rule consistent with this provision, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee is the Primary Plan and the Plan that covers you as a dependent is the Secondary Plan.
- If you are a dependent child whose parents are not divorced or legally separated, the Primary Plan is the Plan that covers the parent whose birthday falls first in the calendar year as an enrollee or employee.
- If you are the dependent of divorced or separated parents, benefits for the Dependent are determined in the following order:
 - first, if a court decree states that one parent is responsible for the child’s health care expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - then, the Plan of the parent with custody of the child;
 - then, the Plan of the spouse of the parent with custody of the child;
 - then, the Plan of the parent not having custody of the child; and
 - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee’s dependent) is the Primary Plan and the Plan that covers you as a laid-off or retired employee (or as that employee’s dependent) is 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 does not apply.
- The Plan that covers you under a right of continuation provided by federal or state law is the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee’s dependent) is 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 does not apply.

CLAIMS & LEGAL ACTION - Continued

- If one of the Plans determines the order of benefits based on 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 rule determines the order of benefits.

If none of the above rules determine the order of benefits, the Plan that has covered you for a longer period of time is the Primary Plan.

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

Effect on the Benefits of This Plan

The Coordination of Benefits provision is applied throughout each Claim Determination Period.

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

If this Plan is the Secondary Plan, it pays the lesser of:

- the Allowable Expenses that were not reimbursed under the other Plan; or
- the amount this Plan would have paid if there were no other coverage.

When the benefits of a government Plan are taken into consideration, the Allowable Expense is limited to the benefits provided by that Plan.

When the Coordination of Benefits provision reduces the benefits payable under this Plan, each benefit will be reduced proportionately and only the reduced amount will be charged against any benefit limits under this Plan.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan and the benefit payments this Plan actually paid as the Secondary Plan, will be recorded as a benefit reserve for you.

As each claim is submitted, the following will be determined: this Plan's obligation to cover services and supplies under this Plan; whether a benefit reserve has been recorded for you; and whether there are any unpaid eligible Allowable Expenses during the Claims Determination Period.

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

Recovery of Excess Benefits

If this Plan pays charges for benefits that should have been paid by the Primary Plan, or if this Plan pays charges in excess of those for which this Plan is obligated to pay, this Plan has the right to recover the actual payment made or the Reasonable Cash Value of any services.

This Plan may seek recovery from any person to, or for whom, or with respect to whom, such services or supplies were provided or such payments made by any insurance company, health care plan or other organization. If requested, you must execute and deliver to this Plan any such instruments and documents as determined necessary to secure the right of recovery.

Right to Receive and Release Information

Without consent or notice to you, information may be obtained from you, and information may be released to any other Plan with respect to you, in order to coordinate your benefits pursuant to this provision. You must provide any information requested in order to coordinate your benefits pursuant to this provision. 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 another Plan, is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim may be denied. If the requested information is subsequently received, the claim will be processed.

CLAIMS & LEGAL ACTION - Continued

■ Payment of Benefits

As used in this provision, any reference to “you” or “your” refers to the covered Member, and also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

Benefits are payable to you, but are also assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient’s payment on the charge, it is the provider’s responsibility to reimburse the patient. Because of Cigna’s contracts with providers, all claims from contracted providers should be assigned.

Plan payment may be made to you for the cost of any covered expenses received from a provider who is not a network provider even if benefits have been assigned. When benefits are paid to you or your Dependents, you or your Dependents 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, such payment may be made to the person’s legal guardian. If no request for payment has been made by the person’s legal guardian, Plan payment may be made to the person or institution appearing to have assumed custody and support of the person.

When a Plan participant passes away, and notice is received that an executor of the estate has been established, benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

When a Plan overpayment has been made, the Plan will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, your acceptance of benefits under this Plan and/or assignment of benefits separately creates an equitable lien by agreement pursuant to which the Plan may seek recovery of any overpayment. You agree that the Plan, in seeking recovery of any overpayment as a contractual right or as an equitable line by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

■ Other Information a Member Needs to Know

Legal Actions

A Member may bring a legal action to recover under the Plan. For legal actions not related to the Plan’s Appeals Procedure, such legal action may be brought no sooner than 60 days, and no later than 3 years, after the time written proof of loss is required to be given under the terms of the Plan.

Relationship Between Cigna and Network Providers

Providers under contract with Cigna are independent contractors. Network providers are neither agents nor employees of Cigna, nor is Cigna, or any employee of Cigna, an agent or employee of Network providers. Cigna will not be responsible for any claim or demand on account of damages arising out of, or in any way connected with, any injuries suffered by the Member while receiving care from any Network provider or in any Network provider’s facilities.

GLOSSARY

Dependent

See ELIGIBILITY.

Employee

See ELIGIBILITY.

Employer

- Community Action Team, Inc.; and
- Any affiliated companies listed in the application of the Employer. The Employer may add an affiliated company after the effective date of the Plan. For that company only, the effective date of the Plan will be considered to be the effective date of the amendment that adds that company.

Injury

An accidental bodily injury.

Maximum Reimbursable Charge

See WHAT'S COVERED? (Covered Expenses).

Medically Necessary/Medical Necessity

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

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

Medicare

Title 18 of the United States Social Security Act of 1965 as amended from time to time and the coverage provided under it. This includes coverage provided under Medicare Advantage plans.

Member

An Employee and any covered Dependent.

Ophthalmologist

A person practicing ophthalmology within the scope of his or her license. This includes a Doctor operating within the scope of his or her license when the Ophthalmologist performs any of the Vision Benefit Covered Expenses.

Optician

A fabricator and dispenser of eyeglasses and/or contact lenses. An Optician fills prescriptions for glasses and other optical aids, as specified by an Optometrist or Ophthalmologist. The state in which an Optician practices may or may not require licensure for rendering these services.

GLOSSARY - Continued

Optometrist

A person practicing optometry within the scope of his or her license. This includes a Doctor operating within the scope of his or her license when the Optometrist performs any of the Vision Benefit Covered Expenses.

Plan

The vision benefits described in this booklet.

Review Organization

The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Doctors, registered graduate nurses, licensed mental health and substance use disorder professionals, and other trained staff members who perform utilization review services.

Service

See ELIGIBILITY.

Sickness

A physical illness.

Vision Provider

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.

You and Your

An Employee.

USERRA RIGHTS AND RESPONSIBILITIES

The federal Uniformed Services Employment and Reemployment Rights Act (USERRA), establishes requirements for Employers and certain Employees who terminate Service with the Employer for the purpose of Uniformed Service. This includes the right to continue the vision coverage that you (the Employee) had in effect for yourself and your Dependents.

“Uniformed Service” means the performance of active duty in the Uniformed Services under competent authority which includes training, full-time National Guard duty and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of the assigned duties.

You must notify your Employer verbally or in writing of your intent to leave employment and terminate your Service with the Employer for the purpose of Uniformed Service. The notice must be provided at least 30 days prior to the start of your leave, unless it is unreasonable or impossible for you to provide advance notice due to reasons such as military necessity.

Continued Vision Coverage

Under USERRA, you are eligible to elect continued vision coverage for yourself and your Dependents when you terminate Service with the Employer for the purpose of Uniformed Service.

The Employer should establish reasonable procedures for electing continued vision coverage and for payment of contributions. See the Plan Administrator for details.

If you do not provide advance notice of your leave and you do not elect continued coverage prior to your leave

Coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service.

However, if you are excused from giving advance notice because it was unreasonable or impossible for you to provide advance notice due to reasons such as military necessity, then coverage will be retroactively reinstated if you elect coverage for yourself and your Dependents and pay all unpaid contributions within the period specified in the Employer’s reasonable procedures.

If you provide advance notice of your leave but you do not elect continued coverage prior to your leave

Coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service, when the duration of Uniformed Service is at least 30 days.

However, coverage will be retroactively reinstated if the Employer has established reasonable procedures for election of continued coverage after the period of Uniformed Service begins, and you elect coverage for yourself and your Dependents and pay all unpaid contributions within the time period specified in the procedures.

If the Employer has not established reasonable procedures, then the Employer must permit you to elect continued coverage for yourself and your Dependents and pay all required contributions at any time during the period of continued coverage, and the Employer must retroactively reinstate coverage.

If you elect continued coverage but do not make timely payments for the cost of coverage

If the Employer has established reasonable payment procedures and you do not make payments according to the procedures, then coverage for you and your covered Dependents will terminate as described in the procedures.

Period of Continued Coverage

During a leave for Uniformed Service, the period of continued coverage begins immediately following the date you and your covered Dependents lose coverage under the Plan, and it continues for a maximum period of up to 24 months.

Cost of Continued Coverage

If the period of Uniformed Service is less than 31 days, you are not required to pay more than the amount that you paid as an active Employee for that coverage for continued coverage.

USERRA RIGHTS AND RESPONSIBILITIES - Continued

If the period of Uniformed Service is 31 days or longer, then you will be required to pay up to 102% of the applicable group rate for continued coverage.

COBRA Coverage

If you are eligible for COBRA continuation coverage, then the COBRA coverage period runs concurrently with the USERRA coverage period. In some instances, COBRA coverage may continue longer than USERRA coverage.

Reinstatement of Coverage

Coverage for an Employee who returns to Service with the Employer following Uniformed Service will be reinstated upon request from the Employee and in accordance with USERRA.

Reinstated coverage will not be subject to any exclusion or waiting period, if such exclusion and/or waiting period would not have been imposed had coverage not terminated as a result of Uniformed Service.

CONTINUATION OF COVERAGE - FMLA

This provision applies if the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), as amended. If you are eligible for FMLA leave and if the Employer approves your FMLA leave, coverage under the Plan will continue during your leave. Contributions must be paid by you and/or the Employer. If contributions are not paid, your coverage will cease. If you return to work on your scheduled date, coverage will be on the same basis as that provided for any active Member on that date. If your coverage ends during FMLA leave, a COBRA qualifying event occurs if you do not return to work on the date you are scheduled to return from your FMLA leave. See the Plan Administrator with questions about FMLA leave.

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA

COBRA continuation coverage is a temporary extension of coverage under the Plan, and was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Under this federal law, you and/or your covered Dependents (a covered Member) if a COBRA qualified beneficiary, must be given the opportunity to continue Plan coverage when there is a "qualifying event" that would result in loss of coverage under the Plan. The law permits continuation of the same Plan coverage under which the qualified beneficiary was covered on the day before the qualifying event, unless the qualified beneficiary moves out of the Plan's coverage area or the Plan is no longer available. If coverage options are available, a qualified beneficiary has the same options to change coverage as others who are covered under the Plan.

COBRA continuation coverage is available for you and your covered Dependents 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.
- 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 loss of coverage under the Plan:

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

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

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

The following individuals are not qualified beneficiaries for the purposes of COBRA continuation coverage: domestic partners, spouses who do not meet the definition of spouse under federal law, and children (such as stepchildren, grandchildren) who have not been legally 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 provisions "Secondary Qualifying Events" and "Medicare Extension for 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) elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend 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. Under no circumstances with 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 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, both 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 individuals covered under the extension, 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 Coverage" will also apply to the disability extension period.

Medicare Extension

When the qualifying event is your termination of employment or reduction in work hours, and you became covered under Medicare (Part A, Part B or both) within the 18 months before the qualifying event, the maximum COBRA continuation period for you is 18 months from the date of your termination of employment or reduction in work hours, and for your Dependents the maximum continuation period is 36 months from the date you became covered under Medicare.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate when any of the following occurs:

- the end of the COBRA continuation period of 18, 29 or 36 months; as applicable.
- failure to pay the required cost of coverage as described in "COBRA Premiums".
- cancellation of the Employer's Plan.
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under Medicare (Part A, Part B or both).

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

- 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. In such a situation, COBRA continuation coverage will continue until the earlier of: the date the condition becomes covered under the other plan or the occurrence of any of the events listed above.
- after the date the qualified beneficiary qualifies as described in “Disability Extension”, the beneficiary is no longer disabled.
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving COBRA continuation (e.g., fraud).

Employer Notice Requirements

The Employer is required to provide the following notices:

- **Initial Notice** - An initial notice of COBRA continuation rights must be provided within 90 days after Plan coverage 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 election notice.
- **Election Notice** - COBRA continuation coverage will be offered to qualified beneficiaries only after the Employer’s representative or Plan Administrator has been timely notified that a qualifying event has occurred, and must be provided to you and/or your Dependents within the timeframe required by COBRA.

When the qualifying event is termination of employment, reduction of employment hours or the Employee’s death, a COBRA continuation election notice must be provided to you and/or your Dependents:

- if the Plan provides that the COBRA continuation coverage period starts upon the loss of coverage, within 44 days after loss of coverage under the Plan.
- if the Plan provides that the COBRA continuation coverage period starts upon the occurrence of a qualifying event, within 44 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

The COBRA continuation election notice will list the individuals who are eligible for COBRA continuation coverage, and provide information about the applicable cost of coverage. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election in writing no later than the due date stated in the election notice. If written notice is mailed, it must be post-marked no later than the due date stated in the election notice. If you do not make proper notification by the due date stated in the election 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. COBRA 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 COBRA continuation 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 coverage.

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

Cost of COBRA Continuation Coverage

Each qualified beneficiary may be required to pay the entire cost of COBRA 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 cost 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, the Employee or family member will be charged 102% (or 150%, if applicable) of the active Employee cost of coverage. If the spouse or one Dependent child alone elects COBRA continuation coverage, the individual will be charged 102% (or 150%, if applicable) of the active Employee cost of coverage. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%, if applicable) of the applicable family cost of coverage.

The first COBRA continuation coverage payment must be made no later than 45 calendar days after the date of your election (if mailed, this is the date the election notice is postmarked). The qualified beneficiary is responsible for making sure that the amount of the first payment is enough to cover the entire initial period from the date coverage would have otherwise terminated, up to the date the qualified beneficiary makes the first payment. If the first payment is not made within the 45-day period, all COBRA continuation rights under the Plan will be lost. Claims incurred during the period covered by the initial payment period will not be processed until the payment is made.

After the first payment is made, the qualified beneficiary is required to pay for each subsequent period of coverage. If payment is made on or before its due date, coverage under the Plan will continue for that coverage period without any break.

A grace period of 30 days after the first day of the coverage period will be given to make each periodic payment. 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 payment is received after the due date, 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 required payment is received before the end of the grace period, coverage will be reinstated back to the beginning of the coverage period. This means that any claim(s) submitted while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated. If payment is not made before the end of the grace period for that coverage period, all rights to COBRA continuation under the Plan will be lost.

You Must Give Notice of Certain Qualifying Events

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

- your divorce or legal separation.
- your child no longer qualifies as a Dependent under the Plan.
- the occurrence of a secondary qualifying event as described in “Secondary Qualifying Events” (this notice must be received prior to the end of the initial 18-month or 29-month COBRA period). See “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.).

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

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. Coverage is subject to the Plan's notice and/or application process for active Employees adding a new Dependent. Only your newborn or adopted Dependent child is a qualified beneficiary for the purpose of continuing COBRA coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. Any other Dependent added while your coverage is being continued is not a qualified beneficiary for the purpose of continuing COBRA coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event.

Health FSA

The maximum COBRA coverage period for a health flexible spending arrangement (Health FSA), if maintained by your Employer, ends on the last day of the Flexible Benefits Plan Year in which the qualifying event occurred.

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).

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 enroll for or change coverage within 31 days of the date you meet criteria described in the following provisions.

Change of Status

A change in status is defined as:

- a change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation; or
- a change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent; or
- a change in employment status of Employee, spouse or Dependent child 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; or
- changes in employment status of Employee, spouse or Dependent child resulting in eligibility or ineligibility for coverage; or
- a change in residence of Employee, spouse or Dependent child to a location outside of the Employer's network service area; or
- changes which cause a Dependent child to become eligible or ineligible for coverage.

Court Order

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

Medicare or Medicaid Eligibility/Entitlement

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

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.

EFFECT OF SECTION 125 TAX REGULATIONS ON THIS PLAN - Continued

Changes in Coverage of a Spouse or Dependent Child Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent child:

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

ERISA GENERAL INFORMATION

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA).

The name of the Plan is: Community Action Team, Inc.

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

Community Action Team, Inc.

124 N. 18th St.

St. Helens, OR 97051

503-397-3511

The Employer Identification Number (EIN) is: 93-0554156

The Plan Number assigned by the Employer is: 501

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

The name, address and ZIP code of the designated agent for service of legal process is: Employer named above

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

Contributions are determined by the Employer. Employee contributions, if any, for a time period for which the Employee is not covered under the Plan may be refunded by the Employer. Please see your Plan Administrator for details.

The health benefits described in this booklet are self-funded by the Employer. The Employer is fully responsible for the self-funded benefits. Cigna provides contract administration by processing claims and provides other services to the Employer related to the self-funded benefits. Cigna does not insure nor guarantee the self-funded benefits.

The fiscal records of the Plan are maintained on the basis of Plan years ending June 30.

The preceding pages set forth the Plan's eligibility requirements, termination provisions and a description of the circumstances that may result in disqualification, ineligibility, or denial or loss of benefits.

Procedures to be followed in presenting claims for benefits and what to do when claims are denied in whole or in part are described in CLAIMS & LEGAL ACTION.

Plan Type

The Plan is a health care benefit plan.

Plan Trustee(s)

A list of the Trustee(s) of the Plan, if any, including name, title and address, is available upon request to the Plan Administrator.

ERISA GENERAL INFORMATION - Continued

Collective Bargaining Agreement(s)

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and whether a particular employer or employee organization is a sponsor. A copy of the agreement, if any, is available for examination upon written request to the Plan Administrator.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest Annual Report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- You may receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

However, employers with fewer than 100 plan participants at the beginning of the plan year are not required to: furnish statements of the plan's assets and liabilities and receipts and disbursements or allow examination of the Annual Report, or furnish copies of the Annual Report or any Terminal Report.

Continue Group Health Plan Coverage

If a group health plan is subject to COBRA, you may be eligible to continue health care coverage for yourself or your Dependents if there is a loss of coverage under the plan as a result of a COBRA qualifying event. You or your Dependents may have to pay for such coverage. You may review the documents governing the plan or the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including the employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

STATEMENT OF ERISA RIGHTS - Continued

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain without charge copies of documents relating to the decision and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

Assistance With Your Questions

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