VISION PLAN

The People's United Bank Vision Plan, administered by Cigna, gives you and your family access to quality vision and eye care.

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). This document is a Summary Plan Description (SPD) of the health and welfare benefit plans sponsored by People's United Bank, N.A. The company reserves the right to change, amend, or discontinue any plan or program described in this document. This document is intended for informational purposes only and does not constitute an employment agreement for any recipient. If there is a conflict between this SPD and the insurance contract or governing plan document, the terms of the insurance contract or governing plan document will control, rather than this document, unless otherwise required by law.

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This section, combined with the *Participating in the People's United Bank Group Benefits Plan* and *Rules, Regulations and Plan Administration* sections, make up the Summary Plan Description for the Vision Plan.

Type of Plan Administration and Funding

The Vision Plan is fully insured. Benefits are provided under a group insurance contract entered into between People's United Bank and Cigna Health and Life Insurance Company (Cigna). Claims for benefits are sent to the Insurance Company.

The Insurance Company is responsible for paying claims, not People's United Bank. Insurance premiums for employees and their families are paid by employees' with pre-tax payroll deductions.

How the Plan Works

The Vision Plan includes the following options when you need care:

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

A Participating Provider network consists of a group of local practitioners who contract directly or indirectly with Cigna to provide services to members. You may receive a listing of Participating Providers by calling the member services number on your benefit identification card, or by visiting www.myCigna.com.

Emergency Services

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

How to File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out- of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

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

Claim Reminders:

- Be sure to use your member ID and account/group number when you file Cigna's claim forms, or when you call the Cigna claim office.
- Your Member ID and account/group number are located on your benefit identification card.
- Be sure to follow the instructions listed on the back of the claim form carefully when submitting a claim to Cigna.

Timely Filing of Out-of-Network Claims

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

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

Schedule of Vision Benefits

The following table shows a summary of the Vision Plan benefits:

Services	In-Network *Coverage Level - Plan will pay 100% after any copayment, subject to any maximum shown below*	Out-of-Network *Maximum Reimbursement- Plan will reimburse you at 100%, subject to any maximum shown below*
Standard Eye Exam (One per calendar year)	$15 copayment	$50
Lenses & Frames **Eyeglass Lenses** (One pair per calendar year) Single Vision Lenses Bifocal Lenses Trifocal Lenses Lenticular Lenses **Frames** (One pair in any 2 calendar years)	$25 copayment* * Lenses & Frames Copay does not apply to Contact Lenses 100% 100% 100% 100% 100% up to $150	 $50 $75 $100 $80 $70
Contact Lenses/Contact Lens Exam (fitting & evaluation) (in lieu of glasses, one pair or single purchase per calendar year) Elective Therapeutic	 100% up to $150 100% up to $150	 $105 $105

Covered Expenses

Benefits include:

- Examinations – One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses.
- Lenses (Glasses) – One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms).
  - Polycarbonate lenses for children under 18 years of age;
  - Oversize lenses;
  - Rose #1 and #2 solid tints;
  - Progressive lenses covered up to bifocal lenses amount.
- Frames – One frame – choice of frame covered up to retail plan allowance.
- Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens materials as well as the cost of supplemental contact lens professional services including fitting and evaluation, up to the stated allowance.
- Coverage for Therapeutic contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or 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 Vision Benefits*.

Expenses Not Covered

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

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

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

Exclusions and General Limitations

Exclusions

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

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

General Limitations

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

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

Coordination of Benefits

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

DEFINITIONS

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

Plan

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

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

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

Closed Panel Plan

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

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

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.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments that is covered in full or in part by any Plan covering 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 your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

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

Reasonable Cash Value

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

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

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

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

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

Recovery of Excess Benefits

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

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

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide Cigna with any information they 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 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles

Cigna will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

a. a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
b. a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
c. an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;
d. the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;
e. an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;
f. an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

Cigna will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

Payment of Benefits

To Whom Payable

Vision 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.

Cigna may, at its option, make payment to you for the cost of any Covered Expenses even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

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

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

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

Recovery of Overpayment

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

Notice of an Appeal or Grievance

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

Cigna Vision Second Level Appeals Address

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

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

When You Have a Grievance or an Appeal

When You Have A Grievance Or An Appeal

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

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

START WITH CUSTOMER SERVICE

Cigna is there to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call Cigna's toll-free number and explain your concern to one of Cigna's Customer Service representatives. Please call Cigna at the Customer Service toll-free number that appears on your benefit identification card, explanation of benefits or claim form.

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

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

APPEALS PROCEDURE

Cigna has appeals procedures for coverage decisions based on the Medical Necessity of requested services, and coverage decisions based on other criteria. To initiate an appeal, you must submit a request for an appeal in writing, within 180 days of receipt of a denial notice, to the following address:

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

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

APPEALS OF MEDICAL NECESSITY DECISIONS

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by an appropriate clinical peer or peers. A "clinical peer" is a Physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and for a mental health review concerning: a child or adolescent substance abuse disorder or a child adolescent mental disorder, holds a national board certification or a doctoral level psychology degree with training and clinical experience in child and adolescent substance abuse disorder or child and adolescent mental disorder, as applicable; for an adult substance use disorder or an adult mental disorder, holds a national board certification in psychiatry or a doctoral level psychology degree with training or clinical experience in the treatment of adult substance use disorders or adult mental disorders, as applicable.

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

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

You may request that the appeal process be expedited if: (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you

severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay, or health care services after receiving emergency services and not yet discharged from a facility.

Cigna's Physician Reviewer, or your Physician, will decide if the expedited appeal criteria apply. When an appeal is expedited, Cigna will respond orally with a decision to you and your representative or provider within the lesser of: 72 hours after the appeal is received or two working days after the required information is received, followed up in writing. For expedited appeals involving any of the following substance abuse or mental disorders, a decision will be completed and communicated within 24 hours after the appeal is received:

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

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

Appeals of Coverage Decisions Not Based on Medical Necessity

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Cigna will notify you not later than three business days after receiving your appeal that you are entitled to submit written material for Cigna to consider when reviewing your appeal.

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

Appeal to the State of Connecticut

If you are dissatisfied with the decision of Cigna's appeals review regarding Medical Necessity, clinical appropriateness, health care setting, level of care or effectiveness, or a rescission of coverage or determination of ineligibility for coverage, you, or your provider with your consent, may file a written appeal for review with the State of Connecticut, within 120 days after the determination. The external review program is a voluntary program.

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

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

Appeals to the State of Connecticut must be submitted to:
Connecticut Insurance Department
Attn: External Review
P.O. Box 816
Hartford, CT 06142-0816

For overnight delivery only, please mail your application for external review to:
Connecticut Insurance Department
Attn: External Review
153 Market Street, 7th Floor
Hartford, CT 06103

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

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

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

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

- for standard external reviews, 45 calendar days;
- for standard external reviews involving an experimental or investigational treatment or service, 20 calendar days;
- for expedited external reviews, 72 hours;
- for expedited external reviews involving an experimental or investigational treatment or service, five calendar days; and
- for expedited external reviews involving a substance abuse or mental disorder coverage determination, as expeditiously as the covered person's medical condition requires, but not later than 24 hours after the IRO receives the assignment from the commissioner to complete its review.

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

Expedited Appeal to the State of Connecticut

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

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

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

The Connecticut Insurance Commissioner will immediately assign qualified expedited external appeal review requests to an Independent Review Organization (IRO). The IRO will conduct a preliminary review of the appeal and accept the appeal for expedited review within one calendar day after receipt of the appeal. The IRO will immediately notify you or your provider in writing as to whether your appeal has been accepted for full review and if not accepted, the reasons why the appeal was not accepted for full review.

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

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

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the date of service, if applicable, the health care professional and the claim amount; the specific reason or reasons for the adverse determination, including any applicable Medical Necessity denial code and its corresponding meaning, and Cigna's reviewer's understanding of the appeal; a description of Cigna's decision in clear terms, and reference to the specific plan provisions and/or scientific or clinical rationale on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing the procedures to initiate the next level of appeal, any voluntary appeal procedures offered by the plan; and the claimant's right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; if Cigna's own criteria is used for a substance abuse or mental disorder coverage review, a link to their website documentation regarding that substance abuse or mental disorder criteria; the titles and qualifying credentials of the individuals participating in the review process.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the appeal decision. 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.

Contacting the State of Connecticut

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

State of Connecticut
Insurance Department, Consumer Affairs Unit
P.O. Box 816
Hartford, CT 06142-0816
Phone: (860) 297-3900, 1-800-203-3447
Fax: (860) 297-3872
E-mail: cid.ca@ct.gov

Office of the Healthcare Advocate
P.O. Box 1543
Hartford, CT 06144
Phone: Toll Free at: 1-866-HMO-4446
Fax: (860) 297-3992
E-mail: Healthcare.advocate@ct.gov

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

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. However, a court may require you to complete the Appeals Procedure before proceeding with such a civil action. However, no action will be brought at all unless brought within three years after a claim is submitted for In-Network Services or for Out-of-Network Services.

Definitions

Employer
The term Employer means the Policyholder and all Affiliated Employers.

Injury
The term Injury means an accidental bodily injury.

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.

Medically Necessary/Medical Necessity
“Medically necessary” or “medical necessity” means health care services that a physician/dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical/dental practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
- not primarily for the convenience of the patient, physician/dentist or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For the purposes of this definition, “generally accepted standards of medical/dental practice” means standards that are based on credible scientific evidence published in peer-reviewed medical/dental literature generally recognized by the relevant medical/dental community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

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

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.

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.

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

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

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.

Termination of Insurance

EMPLOYEES
Your insurance will cease on the earliest date below:
- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is cancelled.
- the last day of the calendar month in which your active service ends except as described in the *Rules, Regulations and Plan Administration* section.

Retirement
If your active service ends because you retire, and you are under age 65, your insurance will be continued until the earlier of: a) the date on which your Employer stops paying premium for you or otherwise cancels the insurance; or b) your 65th birthday.

DEPENDENTS
Your insurance for all of your Dependents will cease on the earliest date below:
- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is cancelled.

The insurance for any one of your Dependents will cease on the last day of the month in which that Dependent no longer qualifies as a Dependent.