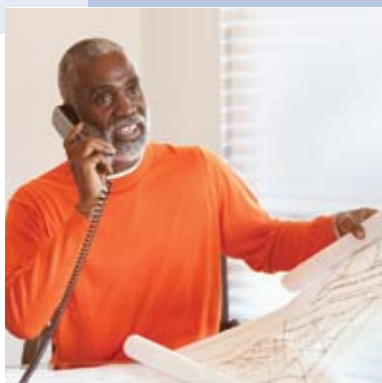


SMALL GROUP PLANS



SMALL GROUP ADMINISTRATION MANUAL



FLORIDA

CIGNA Small Group Enrollment Services

P.O. Box 30364, Tampa, FL 33630-3364

1-877-484-5964



Welcome to CIGNA

Dear Small Group Client,

CIGNA HealthCare is pleased to be your health care partner for the coming year. Please be sure to carefully review all of the enclosed materials to become familiar with the administration of your groups health benefit plan. This manual has been prepared as a guide to help you enroll or terminate members and report changes for your group health benefit plan.

Questions regarding the administration of your plan should be directed to CIGNA Small Group Enrollment Services. You may also call your agent or log on to your CIGNA Small Group Employer Web site. See the front page of this manual for helpful numbers and web addresses.

This manual explains the processes associated with the administration of your group health plans. The information contained in this manual does not alter or waive the terms and conditions of the plan documents. The plan documents may be in the form of summary plan descriptions, booklets, certificates, insurance policies, or similar documents. If there is a conflict between this manual and the terms and conditions of the plan documents, the plan documents will govern. From time to time, this manual is subject to change by CIGNA HealthCare. In addition, this manual does not set forth your legal obligations relating to the administration of your plans. If you have questions about such legal obligations, please contact your attorney.

Table of Contents

SECTION I: ELIGIBILITY & ENROLLMENT – Page 1

- Eligible Employees
- Eligible Dependents
- Handicapped Children
- Effective Date of Coverage
- Enrolling New Employees: Completing the Enrollment/Change Form
- Identification Cards
- Requesting New Identification Cards

SECTION II: CHANGES – Page 5

- Addition of Dependent Coverage
- Enrollment after an Open Enrollment period
- Special Enrollment after Open Enrollment period
- Enrollment Due to Loss of Prior Creditable Coverage
- Addition of Dependent Coverage
- Medical Plan Election/Medicare Primacy (TEFRA, DEFRA, COBRA, OBRA)

SECTION III: TERMINATIONS – Page 10

- Termination Effective Date
- Reporting Terminations
- Termination: Completing the Enrollment/Change Form

SECTION IV: CONTINUATION PROVISIONS – Page 12


- Continuation of Coverage
- COBRA Continuation
- Conversion to Non-Group Coverage
- Conversion: Completing the Enrollment/Change Form

SECTION V: MONTHLY BILLING STATEMENT – Page 15

- Monthly Billing Invoice

SECTION VI: CLAIMS ADMINISTRATION – Page 17

SECTION VII: PHARMACY CLAIMS ADMINISTRATION – Page 18



Below is a list of contact areas to help you with more specific questions or concerns.

MEDICAL COVERAGE AND CLAIM ISSUES

Customer Service
1-800-CIGNA24
(1-800-244-6224)

GENERAL QUESTIONS, ENROLLMENT, ELIGIBILITY AND BILLING ISSUES

Small Group Employer Services
1-877-484-5964
Fax 1-877-484-5965

ENROLLMENT /CHANGE FORMS

Employer Services
PO Box 30364
Tampa, Florida 33630-3364
Fax: 1-877-484-5965

MONTHLY BILLING INVOICE

Please mail your monthly premium payment to:
Connecticut General Life Insurance
PO Box 105551
Atlanta, Georgia 30348-5551

SECTION I: ELIGIBILITY & ENROLLMENT

ELIGIBLE EMPLOYEES

Eligibility for membership is based on the following:

■ Enrollment During Scheduled Open Enrollment Period

Each employee must complete a CIGNA Small Group Employee Enrollment/Change of Coverage Form (Enrollment/Change Form) before the end of the designated Open Enrollment period. Enrollment Services must receive all applications taken during open enrollment no later than 31 days after the conclusion of the Open Enrollment period.

■ Enrollment for New Hires

A new employee who is enrolled during a time other than during Open Enrollment must complete an Enrollment/Change Form no later than 31 days after his or her date of eligibility. If the application is not completed during this period, the employee's eligibility will be postponed until the next scheduled Open Enrollment.

Note: If there is an eligibility waiting period for new employees, the enrollment period for completing the Enrollment/Change Form is extended to include the waiting period. If your plan is subject to Internal Revenue Code Section 125, check your Section 125 Plan Document to determine if employees are allowed to enroll after the waiting period

■ Re-enrollment During Open Enrollment

An employee who enrolled in your CIGNA group health plan during a previous Open Enrollment, *may not be required to complete a new Enrollment/Change Form* if he elects to remain with CIGNA HealthCare during a subsequent Open Enrollment period. Your company's employment policies govern this requirement.

■ Prospective Applicant who Rejects CIGNA HealthCare During Open Enrollment or New Hire Opportunity

An employee who does not take the opportunity to join CIGNA HealthCare during an open enrollment or new hire situation, may enroll himself/herself and all eligible family members during the next scheduled Open Enrollment.

■ Late Enrollment

CIGNA HealthCare does not permit late enrollments. Enrollment/Change Forms for employees and dependents that are deemed late enrollments will be returned to you by Enrollment Services with the appropriate explanation. These employees/dependents may re-apply during the next scheduled Open Enrollment.

An employee is considered to be a late enrollment when he or she elects coverage more than 31 days after his or her date of eligibility or, who again elects coverage after canceling his or her payroll deductions. A dependent is considered to be a late enrollment if the employee either elects dependent coverage more than 60 days after the dependent's date of eligibility, or reapplies for dependent coverage after canceling his or her payroll deductions.

ELIGIBLE DEPENDENTS

An eligible dependent is defined as an employee's:

- Legal spouse
- Children under 19 years of age, who are (a) dependent upon the employee for support, and (b) living in the employee's household.
- Children 19 years of age or older until the end of the calendar year in which the child reaches age 25, provided the child is both primarily supported by the employee and either living in the employee's household or enrolled as a full-time or part-time student .
- Children 19 years of age or older who are unmarried and incapable of self-sustaining employment because of mental retardation or physical handicap.
- If elected, children 19 years of age or older, until the end of the calendar year in which the child reaches age 30. This is provided that the child is unmarried and does not have a dependent of his or her own and is a resident of Florida or a full-time or part-time student. It is also provided that the child is not covered as a named subscriber, insured, enrollee or covered person under any other group, blanket or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

The term **children** includes the employee's natural children, a foster child, a child born to a Dependent child of the employee's until such child is 18 months old, adopted children, stepchildren, children supported by the employee according to the terms of a court order and children for whom the employee is appointed legal guardian.

If a dependent's group coverage in the health plan terminates, coverage in the health plan may be continued through the dependent's right to become a **COBRA Continuant** or by exercising the **Conversion to Non-Group Coverage**. (See Section IV: Continuation Provisions, for instructions on submitting COBRA and conversion applications.)

HANDICAPPED CHILDREN

Membership in the health plan for a dependent child who reaches his or her 19th birthday may be continued indefinitely, if the child is mentally or physically incapable of self-sustaining support. The disability must have commenced prior to the child's 19th birthday.

A handicapped child must be:

- Unmarried
- Emotionally and or physically incapable of earning a living
- Wholly dependent upon the employee for support.
- Continuously incapacitated and dependent upon the employee from the time the child reaches the maximum age.

Certification of Disability/Handicapped Children

Approximately two months before the dependent reaches the maximum dependent age under your plan, the employee will receive a letter from CIGNA HealthCare, together with a Questionnaire for Verification of Dependent Eligibility and a Physician Form, notifying the employee that the dependent's disability must be verified in order for coverage to continue beyond the maximum age limit.

The Questionnaire for Verification of Dependent Eligibility

The employee must complete Section B of the Questionnaire for Verification of Dependent Eligibility, sign and date the form, and return it along with the completed Physician Form to CIGNA HealthCare at the Enrollment Services address listed on the form.

What to Expect

CIGNA HealthCare will review the questionnaire, obtain additional information as needed and notify the employee of the approval or rejection of the request to continue the dependent's coverage beyond the maximum age limit. Depending upon the nature of the dependent's disability, CIGNA HealthCare will request annual re-verification of disabled status. An approved handicapped dependent will not require additional annual re-verification.

EFFECTIVE DATES OF COVERAGE

Effective Dates of Coverage will be determined according to the following:

■ Enrollment During Scheduled Open Enrollment Period

Coverage becomes effective on the 1st or 15th of the month as indicated in your Group Contract.

■ New Hire Enrollment

Coverage becomes effective on the date each employee completes the eligibility waiting period, if applicable. If coverage becomes effective between the 1st and 15th of the month, premium will be charged for the entire month. If coverage becomes effective between the 16th and the last day of the month, premium will not be charged for that month and premium charges will commence on the 1st of the following month.

■ Addition of a Newly Acquired Dependent

Coverage becomes effective on the dependent's date of eligibility. If coverage commences between the 1st and the 15th of the month, premium is payable for the entire month. If coverage begins between the 16th and the last day of the month, premium will not be charged for that month. Premium charges will commence on the first day of the next month.

The date of eligibility is the date the employee acquires the dependent through marriage (spouse and or stepchildren), birth, foster child, adoption, grandchildren to age 18 months, court order, or legal guardianship. An Enrollment/Change Form with the addition of the dependent must be completed and submitted to Enrollment Services prior to or within 60 days after the dependent's date of eligibility. If the Enrollment/Change Form is received between 31 and 60 days after the birth of a newborn or birth or placement of an adopted child, CIGNA may charge an additional premium from the date of birth or placement. If the Enrollment/Change Form is received within 31 days of the date of birth of a newborn or birth of a newborn or birth or placement of an adopted child, an additional premium may be charged from the 31st day after the birth or placement. (See Section II: Changes)

■ Former Employee Returning to Work

Former employees who are rehired and return to work within six months of their termination date may not be required to satisfy any new-hire waiting period as noted in the Group Policy. If a former employee is rehired and returns to work any time after six months from the termination date, he or she must again serve your new employee waiting period, if any. A new Enrollment/Change of Coverage form must be completed and sent to Enrollment Services within 31 days of the rehire date.

■ Request to Re-enroll a Former Dependent During an Off Open Enrollment Time of the Year

An employee who seeks to add an eligible dependent who was previously covered, during an off open enrollment time of the year must wait until the next scheduled open enrollment to re-enroll the dependent. The exception is a former dependent student, whose group coverage terminated because he or she ceased to be a full-time student and who resumes full-time student status. If he or she still qualifies according to the age definition of a full-time student, he or she may be re-enrolled without waiting until the next scheduled Open Enrollment. The effective date of coverage will be the first day of the semester.

ENROLLING NEW EMPLOYEES:

Enrolling New Employees

Use the Enrollment/Change Form to enroll an employee for medical benefits. The Enrollment/Change form can be found at www.CIGNAforSmallEmployers.com

IDENTIFICATION CARDS

Each covered employee and dependent will receive a personalized Identification Card, which must be presented to his or her provider whenever health care services are requested. The Identification Card is not a guarantee of benefits. Its primary function is to give providers the information needed to verify eligibility at the time services are rendered. The Identification Card discloses the Member's Name, ID Number, Group Number (employer's account number), Phone Number and Effective Date of Coverage.

Identification Cards for all enrolled family members are mailed directly to the employee's home address.

Incorrect Identification Cards

If an employee or dependent receives an Identification Card with incorrect information, it should be reported to the CIGNA Enrollment Services immediately. CIGNA will arrange for a corrected Identification Card, which the employee or dependent should receive within two weeks. The incorrect card should be destroyed as soon as the corrected card is received.

REQUESTING NEW IDENTIFICATION CARDS

Employee may request this change by phoning CIGNA

An employee may request new ID cards for him or herself and or a covered dependent by phoning 1-800-CIGNA-24.

SECTION II: CHANGES

ADDITION OF DEPENDENT COVERAGE

If an employee is not eligible for dependent coverage when he or she initially enrolls in the health plan, dependent coverage may be added on the date the employee acquires his or her first eligible dependent. Refer to “Section I: Eligibility & Enrollment” for the definition of Eligible Dependents.

Each dependent must be added prior to or within 60 days following his or her date of eligibility. A dependent addition reported to Enrollment Services more than 60 days following his or her date of eligibility will be considered a late enrollment and will be rejected. The dependent will then be required to wait to be added until the next scheduled Open Enrollment.

An **Employee Enrollment/Change Form** must be completed and sent to Enrollment Services when an employee adds dependent coverage or adds new dependents to his or her current family coverage. If dependents are added on separate effective dates, the employee must complete a separate Enrollment/Change form for the dependents added on each effective date.

ENROLLMENT AFTER AN OPEN ENROLLMENT PERIOD

Employees may experience specific circumstances that allow them to enroll in this plan during time other than during Open Enrollment.

1. If, after the Open Enrollment Period, an employee becomes eligible for coverage as an Employee or a Dependent, he or she may enroll within 60 days of the day on which he or she met the eligibility criteria. To enroll, the employee must submit an Enrollment/Change Form. If so enrolled, the effective date of coverage will be the day on which the employee met the eligibility criteria.

If the employee does not enroll within 60 days, the next opportunity to enroll will be during the next Open Enrollment Period.

2. If an employee is enrolled for coverage, he or she may enroll a newborn child prior to the birth of the child or within 60 days after the child’s birth. To enroll a newborn child, the employee must submit an Enrollment/Change Form. If so enrolled, the effective date of coverage for the newborn child will be the date of the child’s birth.

If the employee does not enroll a newborn child within 60 days, the next opportunity to enroll the child will be during the next Open Enrollment Period.

3. If an employee is enrolled for coverage, he or she may enroll a foster child, adopted child or a child for whom the employee has been granted legal guardianship within 60 days of the date the child is legally placed with the employee for adoption or within 60 days of the date the employee is granted legal guardianship. To enroll a foster child, adopted child or a child for whom the employee is the legal guardian, the employee must submit an Enrollment/Change Form. If so enrolled, the effective date of coverage for the child will be the date of legal placement of the child for adoption or the date of court ordered legal guardianship.

If the employee does not enroll a foster child, adopted child or a child for whom he or she is legal guardian within 60 days, the next opportunity to enroll the child will be during the next Open Enrollment Period.

SPECIAL ENROLLMENT AFTER OPEN ENROLLMENT PERIOD

There are special circumstances under which an individual who was eligible but did not enroll for coverage may be eligible to enroll him or herself and any eligible Dependents outside of the Open Enrollment Period.

After the Open Enrollment Period, the employee may submit an Enrollment/Change Form for him or herself and any eligible Dependents within 31 days of the date of the following events:

1. Marriage
2. Birth of a dependent newborn child or grandchild (an employee has up to 60 days to add a newborn child)
3. Adoption of a dependent child or legal placement of a child for adoption or foster child (an employee has up to 60 days to add an adopted child or foster child)
4. Loss of eligibility for other coverage
5. Termination of another employer's contributions to other coverage (e.g., spouse's employer ceases to contribute to spouse's coverage)
6. Exhaustion of COBRA continuation coverage.

If so enrolled, the effective date of coverage will be the day of the event creating eligibility.

If the employee does not enroll within 31 or in some cases 60 days of one of these events, the next opportunity for the employee and any eligible Dependents to enroll will be during the next Open Enrollment Period.

ENROLLMENT DUE TO LOSS OF PRIOR CREDITABLE COVERAGE

If an employee and or his or her dependents did not enroll during the Open Enrollment Period because the employee and the dependents had other creditable health care coverage, they may be eligible to enroll for coverage under this plan if they later lose that coverage. The employee must submit an Enrollment/Change Form to the Group within 31 days of the day that the employee or their dependents:

1. Are no longer eligible for the other coverage for any reason (including separation, divorce or death of the employee)
2. Lost the other coverage because the employer or plan sponsor failed to pay required premium or fees
3. Completed continuation of other coverage as provided under federal or state law

If so enrolled, the effective date of coverage will be the first day of the month following the day on which CIGNA received the Enrollment/Change Form.

If these conditions are not met, or if the employee does not submit an Enrollment/Change Form within 31 days of one of these events, the next opportunity for the employee and any eligible Dependents to enroll will be during the next Open Enrollment Period.

ENROLLMENT BECAUSE OF SECTION 125 LIFE STATUS EVENTS

If you provide your plan under the rules of IRS Code Section 125, you may choose to permit mid-year enrollment of an employee and or his or her dependents if they experience a life status event. You are not required to permit the mid-year change. Examples of allowable life status events are: spouse's plan has a different open enrollment period; there is a significant cost or coverage increase or decrease or the employee moves into or out of your plan's service area. Other situations may be allowable. Please consult your legal counsel or tax advisor for assistance.

ADDITION OF DEPENDENT COVERAGE

Employee/Dependent Instructions

The Employee or his or her Dependent must:

- Complete all pertinent information on the Enrollment/Change of Coverage Form.
- Sign and date the Form.
- Return the Enrollment/Change of Coverage Form to the employer, or the Human Resources or Benefits Manager for completion of the Employer portion of the Enrollment/Change Form.

Employer Instructions

The employer must:

- Complete the Employer section of the Enrollment/Change of Coverage Form.
- Check the employee/dependent information for accuracy and completeness.
- Sign and date the form.
- Send the original to CIGNA Small Group Enrollment Services at P.O. Box 30364, Tampa, Florida 33630-3364
- Give a copy to the employee for his or her records. Please retain a copy for your personnel records as well.

MEDICAL PLAN ELECTION (TEFRA/DEFRA/COBRA/OBRA) MEDICARE PRIMARY

Synopsis of Federal Legislation: The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA); Amending the Age Discrimination in Employment Act (ADEA).

Medicare and Small Group Coverage

Eligibility rules for your employees who are Medicare eligible can be confusing. The responsibility for compliance generally rests with the employer, and there are penalties for failure to comply. CIGNA can provide some assistance but we encourage you to direct questions to your own legal counsel to ensure proper administration of these requirements. Generally, if a group employs 19 or fewer employees, Medicare is considered primary and if your group employs 20 or more employees, the group health plan is considered primary.

When Group Size Changes

When group size changes please complete the “Medicare Certification Form” (Attachment A) and forward along with required payroll records to the Small Group Enrollment Services.

Working Aged

This legislation requires employers with 20 or more employees to provide active employees age 65 and older and their spouses ages 65 and older the same coverage under any group health plan that is offered to younger workers. For these Medicare eligible individuals, the group health plan is the primary payer and Medicare is the secondary payer. This provision is referred to as “Medicare Secondary Payer Rule” and applies to groups with 20 or more employees.

When a small group with 20 or more employees meets federal requirements, CIGNA HealthCare or Group Medical Plan will provide primary coverage to all active employees and their dependents who are Medicare entitled. Medicare will provide secondary coverage for Medicare Part A (Hospitalization) Benefits that may not be fully covered by the Group Medical Plan. Medicare will provide secondary coverage for Medicare Part B (Doctors’ Visits) only if the employee enrolls in Medicare Part B and pays the applicable premium.

When An Employee Becomes Eligible for Medicare

Employees become eligible for Medicare for the following reasons:

- They turn 65
- They have end-stage renal disease at any age
- They qualify as permanently disabled at any age

Determining When the Employer Health Plan is Primary

When individuals, age 65 or older, are covered by an employer group health plan through their own employment or that of their spouse, the TEFRA (Tax Equity and Fiscal Responsibility Act of 1982), and subsequent amendments, require that the employer plan pay as primary, before Medicare, providing the employer has 20 or more employees (full and part time).

The total number of employees is the essential factor in determining whether Medicare or the group plan is primary. Once an employer has 20 or more employees for each working day in each of the previous 20 calendar weeks, the employer plan is the primary payer. If the Group falls below 20 employees and remains below 20 employees for one full calendar year (1/1 – 12/31), then Medicare will become the primary payer on January 1st of the following year. For example, if the Group’s number of employees has reduced to 19 employees on January 15, 2008, the employer must retain fewer than 20 employees through December 31, 2008 (One full calendar year) and Medicare would become primary on January 1, 2009.

An employer is considered to have 20 or more employees for each working day of a particular week if the employer has at least 20 (full and part time) employees on its payroll each working day of that week.

The Group Health Plan will pay before Medicare for the following covered persons providing the above requirements are met:

- Employees who actively continue to work after age 65
- An active Employee's dependent spouse age 65 and older

Determining When Medicare is Primary

Federal law also requires that Medicare benefits be applied before group health plan benefits when individuals, age 65 or older, are covered by an employer group health plan through their own employment or that of their spouse, providing the employer has 19 or fewer employees (both full and part time).

Again the total number of employees is the essential factor in determining whether Medicare or the group plan is primary. A group must have 19 or fewer employees for each working day during the past full calendar year (January thru December) in order for the Group Health Plan to be considered secondary.

Medicare will pay before the Group Health Plan for the following covered persons providing the above requirements are met:

- Active employees who continue to work after age 65
- An active employee's dependent spouse age 65 and older

Coverage for End-State Renal Disease (ESRD)

Special Federal rules apply to all group health plans when an individual is entitled to Medicare benefits on the basis of end-state renal disease (ESRD). Medicare benefits are secondary to benefits payable under an employer plan for services provided to an ESRD member for the first 30 months of Medicare ESRD coverage.

Waiver of Medicare Part B Late Enrollment Penalty

Individuals who delay enrollment in Medicare Part B upon attainment of age 65 are subject to a late enrollment penalty. However, delayed enrollments in Medicare Part B are permitted without penalty if the individual elected group coverage in the Health plan or Group Medical Plan. The waiver ends when group coverage in the Health plan or Group Medical Plan ceases. These individuals must follow specific Medicare enrollment procedures for Medicare Part B in order to avoid the late enrollment penalty. Forms for delayed enrollment can be obtained from your local Social Security office.

Furthermore, if an employee plans to leave active employment and is a member of the health plan or Group Medical plan, Medicare will extend a special seven-month Medicare Part B enrollment period. This period begins three months prior to the date coverage in the health plan or Group Medical Plan ceases.

SECTION III: TERMINATIONS

TERMINATION EFFECTIVE DATE

Employee Termination

An employee's group coverage in CIGNA HealthCare will terminate when the first of the following events occurs:

- The employee terminates full-time employment
- The employee cancels required payroll deductions
- The employee otherwise loses eligibility for coverage

Coverage ceases at midnight on the last day of the calendar month in which the termination event occurs. This is the *Termination Effective Date*.

Dependent Termination

A dependent's group coverage in CIGNA HealthCare will terminate when the first of the following events occurs:

- The dependent reaches the maximum age for dependent children (coverage will continue until the end of the calendar year)
- The dependent marries
- The dependent's eligibility ceases because he or she is no longer an emotionally or physically handicapped child

Coverage ceases at midnight on the last day of the calendar month in which the termination event occurs. This is the *Termination Effective Date*.

Group coverage in CIGNA HealthCare for **all** of an employee's dependents will terminate when the first of the following events occurs:

- The employee's group coverage terminates
- The employee discontinues required payroll deductions for dependent coverage
- The employer discontinues dependent coverage

Coverage ceases at midnight on the last day of the calendar month in which the termination event occurs. This is the *Termination Effective Date*.

REPORTING TERMINATIONS

Employer Obligation

■ **Notify Enrollment Services of Employee and Dependent Terminations on a Notice of Membership Adjustment form.**

Each termination should be reported within 31 days following the Termination Effective Date. Otherwise, you (the employer) could become financially responsible for claims paid and health care services rendered after the Termination Effective Date through the date Enrollment Services receives notification of the termination.

■ **Retroactive Terminations**

Terminations of employees and dependents from Group Coverage must be reported within 31 days of the Terminations Effective Date.

SECTION IV: CONTINUATION PROVISIONS

CONTINUATION OF COVERAGE

Temporary Lay-Off or Leave of Absence

When an employee's full-time service is interrupted due to temporary layoff or leave of absence, his or her coverage for all benefits may be continued for up to 60 days if the contract permits.

Sickness or Injury

In the case of sickness or injury, certain benefits may be continued. Consult your plan document for details.

State Requirements

To determine if your terminated employees may have rights to state continuation benefits, please check your plan documents. If state continuation requirements apply, CIGNA HealthCare will notify the terminated employees of their right to elect state continuation benefits. If they do elect state continuation benefits, you must collect premium from them. Do not terminate them from your CIGNA HealthCare coverage benefit plan until the end of their state continuation period. Continue to remit premium for them to CIGNA HealthCare in accordance with your monthly premium invoice.

COBRA CONTINUATION

Under certain circumstances, the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides covered employees and or their covered dependents with the right to continue group health care benefits for a specific period of time if they experience a qualifying event which results in termination of coverage. COBRA applies to groups with 20 or more eligible employees. COBRA applies to group health coverage, which includes medical, dental, vision care, and prescription drug coverages. COBRA may also apply to Flexible Spending Arrangements (FSA) and Health Reimbursement Arrangements (HRA). The law is specific about employee/employer obligations.

Since COBRA is an employer-directed law, it is strongly recommended that you consult with your own legal counsel to determine your obligations under COBRA.

COBRA Provisions

In general, COBRA provides for a continuation period of up to 18 to 36 months, depending on the qualifying event, if the employer employs 20 or more employees (full and part-time) on more than 50% of the previous calendar year. Qualifying events are limited to those circumstances provided in the law and corresponding regulations such as: termination of employment, divorce or legal separation, death of the employee, the employee's entitlement to Medicare, and loss of dependent child status under the plan. If an individual is determined by the Social Security Administration to be disabled, and specific requirements are met, an 18-month COBRA continuation period can be extended by an additional 11 months, for a total of 29 months.

Employer Obligations Under COBRA

Under COBRA and its corresponding regulations, employers have specific obligations and timeframes for compliance, and as such, must:

- Provide covered employees and spouses with advance General Notice of the COBRA requirements
- Notify the plan administrator or COBRA administrator of qualifying events
- Provide individuals with a notice of COBRA election rights following a qualifying event
- Develop and communicate policies and procedures for individuals to notify the employer of qualifying events

The U.S. Department of Labor has developed a model General Notice which, when appropriately modified and supplemented, may be used to satisfy the initial notice requirement. Upon request, CIGNA will provide an electronic copy of the model General Notice to employers for reference. You may request a copy from CIGNA Small Group Enrollment Services. CIGNA does not offer COBRA administration services.

COBRA Elections

As the policyholder, you must report all terminations and changes to CIGNA to assure proper payment of claims. Complete an Enrollment/Change form, checking the COBRA box in Section A and the appropriate continuation box (e.g., 18, 29 or 36 months). Mail the completed form to the Enrollment Services at the address listed on the Contact Pages of this manual. Any coverage other than medical, dental, vision and/or prescription drug provided by the plan should be canceled as usual on the actual date of termination.

COBRA Premiums

COBRA permits employers to charge up to 102% of the applicable premium for COBRA coverage. During the 11-month disability extension, employers may charge up to 150% of the applicable premium. Monthly premium payments are reported and paid by you (the policyholder) to CIGNA in the usual manner. Do not send individual continuant checks to CIGNA. Continuant checks should be included with active participants in applicable coverage on your monthly payment report.

End of COBRA Coverage Period

Continuation of COBRA coverage for employees and dependents will cease on the earliest of the following dates:

- When all CIGNA group health plans sponsored by the employer terminate
- When all employees/dependents enroll in another group plan, without a pre-existing condition that affects him or her
- When the employee/dependent becomes entitled to Medicare
- Upon the employee/dependent's failure to pay monies due
- Upon the expiration of the maximum continuation period allowed by law
- At the end of the month that begins more than 30 days after the date of final determination that the individual is no longer disabled under the Social Security Act. (Only applies under the 11-month disability extension).

CONVERSION TO NON-GROUP COVERAGE

Right of Conversion

If an employee or an employee's dependent's group coverage terminates for any reason other than failure to pay the required premium for group coverage, and he or she has been continuously covered for at least 3 months immediately prior to termination, he or she may apply for Conversion to Non-Group (Individual) Coverage with CIGNA HealthCare. Application together with payment of the initial premium (first three months) must be submitted to Enrollment Services within 63 days after group coverage terminates. Conversion to Non-Group Coverage is also available to a COBRA Continuant whose coverage terminates for any reason other than non-payment of premium. Application and the initial premium (first three months) must be submitted to Enrollment Services during the final 180 days of the COBRA Continuation Period. Information regarding the benefits and rates of the non-group conversion agreement and an Enrollment/Change Form may be obtained from Enrollment Services. Conversion is available if the group plan is canceled and not replaced within 31 days.

Notification

CIGNA HealthCare will mail an election and premium notice form, including an outline of coverage, within 14 days after an insured or dependent who is eligible for conversion gives notice to CIGNA HealthCare that the insured or dependent is considering applying for the converted policy or otherwise request conversion information. An insured can choose to immediately access conversion upon termination, without exhausting any COBRA or state continuation or choose conversion after exhaustion of any COBRA or state continuation.

Who May Convert

Conversion will be available to any person whose coverage terminates, provided that person:

- Was insured under the group policy and/or a replacement policy for at least three consecutive months prior to termination;
- Was not terminated because he or she failed to pay required premium for the group coverage;
- Is not eligible for Medicare;
- Is not eligible for similar benefits under an insured or non-insured plan

Note: If two or more family members are eligible and apply for conversion, they must **all** be covered under the conversion plan. If a family member who applies for conversion subsequently elects not to convert because he or she is eligible for coverage under another group plan, a continuation option or Medicare, the employee must submit written documentation of the family members' ineligibility to the Conversion Unit.

SECTION V: MONTHLY BILLING STATEMENT

MONTHLY BILLING INVOICE

CIGNA HealthCare provides a **monthly paper billing statement** and or **electronic (eBill) billing statement** that discloses the total charges due for the billed month. Each statement reflects enrollment activity submitted to CIGNA in time to be included on the current invoice, as well as other charges that may not be billed based on eligibility. Enrollment activity that will impact the monthly invoice consists of new enrollments, dependent additions, terminations and COBRA enrollments. Additional changes to the invoice may be because of actions such as the addition, discontinuation or change of benefits or the increase or decrease of rates.

Eligibility Based Billing Policy

All membership driven charges shown on the bill will be calculated using the eligibility data submitted to CIGNA HealthCare. The Billing Census is calculated using the Fifteenth of the Month Wash Method. Therefore, premium is billed on a full month basis rather than pro-rated. The Wash Method is applied as follows.

New Enrollment Wash Method

If a member's *Coverage Effective Date* is on or before the 15th day of the *Month of Coverage*, then premium or other amounts are due for that member for that month.

Example: If March 5 is the member's *Coverage Effective Date*, then premium or other amounts are due for that member for the entire month of March.

If the member's *Coverage Effective Date* is after the 15th day of the *Month of Coverage*, then **no** premium or other amounts are due for that member for that month.

Example: If March 18 is the member's *Coverage Effective Date*, then premium or other amounts are NOT due for that member until the month of April. Coverage for March 18 to March 30 is free.

Termination Wash Method

If a member's *Deemed Termination Effective Date* is on or before the 15th day of the *Month of Coverage*, then **no** premium or other amounts are due for that member for that month.

Example: If March 5 is the member's *Deemed Termination Effective Date*, then NO premium or other amounts are due for that member for the month of March. Coverage for March 1 to March 4 is free.

If a member's *Deemed Termination Effective Date* is after the 15th day of the *Month of Coverage*, then premium or other amounts are due for that member for that month.

Example: If March 18 is the member's *Deemed Termination Effective Date*, then premium or other amounts are due for that member for the month of March.

Premium Due Date Policy

The Premium Due Date is the first day of the Month of Coverage. The normal Bill Day is the day on which CIGNA HealthCare produces and mails each monthly bill.

Example: A bill for the month of March 2008 could be sent to you during the month of February OR during the month of March. In either case, the end of the Grace Period remains March 31, 2008.

Payments

Each invoice is due and payable on the first of the month of service. A cancellation letter is mailed to you if CIGNA does not receive your payment by the end of the grace period.

Remittance should always equal the Total Amount Due on the billing invoice, which means the invoice is paid-as-billed.

Each payment should be sent with the Payment Voucher to the CIGNA HealthCare Lockbox shown on the voucher. If the voucher is not received or becomes misplaced, payment should be sent to the Lockbox address shown on the Contact Pages at the beginning of this manual.

Enrollment/Change Forms should not be included with remittances. Completed Enrollment/Change Forms should be sent directly to Enrollment Services as reflected in the Contact Page at the beginning of this manual.

Terminations

To ensure timely processing of reported terminations, please send terminations to Enrollment Services instead of sending with your payment.

SECTION VI: CLAIMS ADMINISTRATION

CLAIM FORMS

For benefits provided by a participating provider (in-network), there are no claim forms for the employee to complete because the provider submits bills on behalf of the insured.

If your plan allows for coverage to out-of-network providers, the employee must submit all claims to the appropriate claims office. For ease in administration, the claims office address is included on the claim form. Call the number on the back of your ID card if you have questions about a claim.

What to Do

The Employee should call 1-800-CIGNA-24 to obtain a Medical Claims Form to complete. The Medical Claims Form can also be found on the CIGNA HealthCare Website at www.mycigna.com.

The Employee

If an out of network provider is used, the employee is to complete all pertinent sections and sign and date the form. A separate claim form must be used for each family member for whom a claim is filed. The employee can submit an itemized bill instead of having the physician complete the provider section by following the instructions on the back of the claim form.

Employees should make copies of itemized bills – the originals cannot be returned. Canceled checks and balance-due bills are not acceptable substitutes for itemized bills.

Where to Send Claims

Send the completed claims forms and itemized bills to the Claims Office shown on the claims form.

Explanation of Benefits

CIGNA HealthCare's claims processing system sends an Explanation of Benefits (EOB) to the employee each time a claim is processed. The EOB gives clear details about how benefits were determined. An EOB is sent to the employee for each benefit determination made. Depending on your Plan, duplicate copies of EOBs may not be available.

If the employee has used an out of network provider and wants benefits to be paid directly to the physician or provider of service, he or she must sign the authorization section of the claim form. Benefits will be paid directly to the facility for hospitalization. All claims for which CIGNA HealthCare is the secondary payer should be filed along with a copy of the Explanation of Benefits (EOB) from the primary carrier.

Payment of Claims

Most claims are processed within 10 working days of their receipt by the Claims Office. Delays in processing are most often the result of incomplete claim forms submitted to CIGNA or if CIGNA requires additional information from the Provider.

Checking on a Claim

The employee may access www.myCIGNA.com or call the Claims Office during normal business hours at the telephone number shown on the claim form. The employee should have his or her Member Identification Number, which can be found on the Member Identification Card, and the account number available when making the call.

SECTION VII: PHARMACY CLAIMS ADMINISTRATION

WHEN TO FILE A PHARMACY CLAIM

A direct claim should be made to Pharmacy Services to request reimbursement of covered prescription expenses.

What to Do

The Employee should call CIGNA at the number on the back of his or her ID card, to obtain a Pharmacy Claim Form to complete. The Pharmacy Claim Form can also be found on the CIGNA HealthCare Website at www.mycigna.com.

What the Employee Does

The employee is to complete all pertinent sections and sign and date the form. A separate claim form must be used for each family member for whom a claim is filed.

Pharmacy Reimbursement

Requests for pharmacy reimbursement **must** contain the following information:

- Patient name
- Provider name
- Prescription number (ndc#)
- Prescription date
- Name of drug
- Charge for drug

Where to Send Pharmacy Claims

The employee should send the completed claim form and itemized bills to the address shown on the claim form within 180 days of the date the prescription was filled.

Checking on a Claim

The employee may go to www.mycigna.com or call the Claims Office during normal business hours at the telephone number shown on the claim form. Employees should have their Member Identification Number, which can be found on their Member Identification Card, as well as their account number available when making the call.

ATTACHMENT A

TO BE COMPLETED BY EMPLOYER AND MAILED OR FAXED TO:

CIGNA Small Group Enrollment Services
 PO Box 30364
 Tampa, Florida 33630-3364
 FAX 1-877-484-5965

Group Name: _____

Small Group Policy Number: _____

For the purposes of Medicare Coordination of Benefits I hereby certify (check one):

_____ I employ 19 or fewer full and part time employees
And I have enclosed payroll records in the form of Quarterly Wage and Tax Statements for the past full calendar year (January through December).

_____ I employ 20 or more full and part time employees
And I have enclosed payroll records showing I have 20 or more active employees for at least 20 calendar weeks in either the current or preceding year

I fully understand that the requirements of the Law are based on the number of people I employ and not the number of individuals covered under my health plan or the number of eligible employees I may have.

 Signature

 Date



"CIGNA," "CIGNA HealthCare" and the "Tree of Life" logo are registered service marks of CIGNA Intellectual Property, Inc., licensed for use by CIGNA Corporation and its operating subsidiaries. All products and services are provided exclusively by such operating subsidiaries and not by CIGNA Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. In Arizona, HMO plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. and Great-West Healthcare of California, Inc. In Connecticut, HMO plans are offered by CIGNA HealthCare of Connecticut, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare Mid-Atlantic, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company.