

# Administrative Information

This section contains information on the administration and funding for your plans, as well as your rights as a plan participant. While you may not need this information for day-to-day participation in your benefit plans, you should read through this section. It is important for you to understand your rights, the procedures you need to follow and the appropriate contacts you may need in certain situations.

Participation in any of the benefit plans sponsored by Stamford Public Schools should not be viewed as a contract of employment.

## Employer Name, Address and Identification Number

Stamford Public Schools sponsors the plans described in this book. The federal employer identification number assigned for Stamford Public Schools is #06-6001536.

Stamford Public Schools  
Benefits Administration Office  
P.O. Box 9310  
Stamford CT 06904  
203-977-4196 or 203-977-4773

## Plan Administrator

The plan administrator is Stamford Public Schools. Administration of all the plans described in this book is the responsibility of the plan administrator. The plan administrator may be contacted by phone, in person or in writing at the following address:

Stamford Public Schools  
Benefits Administration Office  
P.O. Box 9310  
Stamford CT 06904  
203-977-4196 or 203-977-4773

## Employee Association Agreements

The eligibility of employees represented by an employee association for the benefits described in this book is subject to negotiation between Stamford Public Schools and the applicable union.

## Plan Funding

The benefit plans are funded in different ways, depending upon the type of plan, as described below. Stamford Public Schools and participating employees make contributions to the benefit plans. Employee contributions are determined by the collective bargaining agreement between Stamford Public Schools and the applicable union. Employee contributions for medical, dental and prescription drug coverage and flexible spending accounts are intended to be made on a pre-tax basis in accordance with section 125 of the Internal Revenue Code.

## Stamford Public Schools-Funded Plans

Medical, dental and prescription drug benefits are paid from the general assets of Stamford Public Schools and are not pre-funded or insured. Third party administrators administer the benefits. The name and address of each administrator are listed below. Each benefits administrator has the discretionary authority to determine all benefits in accordance with this benefits book and applicable union collective bargaining agreements. The administrative services provided by the benefits administrator include claims processing and payment.

### Medical

Anthem Blue Cross and Blue Shield  
370 Bassett Road  
North Haven CT 06473  
800-233-4947

### Prescription Drugs

Medco Health  
100 Parsons Pond Drive  
Franklin Lakes NJ 07417  
800-711-0917

### Dental

CIGNA HealthCare  
900 Cottage Grove Road  
Hartford CT 06152  
800-244-6224

The above listed administrators are authorized to make payments on behalf of Stamford Public Schools directly to Physicians, Providers or Hospitals furnishing Covered Services for which benefits are provided under the benefits offered by Stamford Public Schools. However, except as otherwise provided for in any Physician, Provider or Hospital agreement, Anthem reserves the right to make payments on behalf of Stamford Public Schools directly to you or your covered dependent at Anthem's discretion. In the absence of a participating agreement, and one parent or custodian who has custody of a minor dependent child, Anthem will make payments on behalf of Stamford Public Schools to that custodial parent or custodian.

Once Covered Services are rendered by a Physician, Provider or Hospital, Anthem will reject a request not to pay the claims submitted by the Physician, Provider or Hospital. Anthem will have no liability to any person because of its rejection of the request.

You must advise the Physician, Provider or Hospital that you or your dependent is covered under the benefits offered by Stamford Public Schools when arrangements for services are made or as soon as reasonably possible thereafter.

Anthem will not routinely issue a benefit payment on behalf of Stamford Public Schools of less than \$1.00 except upon a written request from you or your covered dependent.

Claims for benefits for Covered Services will be processed within thirty (30) days of the date the claim is received by Anthem. If a claim decision cannot be made within the 30-day period, an extension of up to fifteen (15) days may be requested. Before the end of the initial thirty (30)-day period, Anthem will send a written notice of the reason(s) for the delay.

If the time to process a health claim is extended because requested information is not submitted, the time period requirements for claim processing will be tolled from the date the notice of requested information is sent until the date Anthem BCBS receives a response. Anthem will make a claim decision within fifteen (15) days after receipt of the requested information. You should submit the requested information within forty-five (45) days of receipt of the request.

When Anthem has made payments for Covered Services either in error or in excess of the maximum amount of payment necessary to satisfy the provisions of the benefits offered by Stamford Public Schools, Anthem has the right to recover these payments from one or more of the following as may be appropriate. Anthem will not attempt to recover from you or a Provider, overpayments not made to or held by you or a Provider. Overpayments may be recovered from:

- Any person to or for whom such payments were made;
- Any insurance companies, or
- Any other organizations.

Anthem's right to recover may include subtracting from future benefits payments the amount Anthem has paid in error or in excess. You personally and on behalf of your covered dependents will, upon request, execute and deliver such documents as may be required and do whatever is necessary to secure Anthem's right to recover any erroneous or excess payments.

Under BlueCard, recoveries made from a Blue Cross and/or Blue Shield plan in the BlueCard program or from participating providers of a Blue Cross and/or Blue Shield plan in the BlueCard program can arise in several ways, including, but not limited to, anti-fraud and abuse audits, Provider/Hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Blue Cross and/or Blue Shield plan will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard policies, which generally require correction on a claim-by-claim or prospective basis.

## Insured Plans

The following benefits are insured by a third party:

- Medical benefits under Aetna (plan is closed to new enrollment)
- The basic and voluntary life and accident insurance coverage
- Long term disability coverage for Administrators

The name and address of each insurer is listed below. The administrative services provided by the insurer include claims processing and payment. The master contract for coverage specifies the time and the circumstances under which the insurer is to pay for benefits. For example, the insurer would not have to pay claims incurred after the contract is terminated. The insurer has the discretionary authority to determine all benefits according to the terms of the official policy documents and applicable union collective bargaining agreements.

### Medical

Aetna Inc.  
151 Farmington Avenue  
Hartford CT 06156  
888-287-4295

### Life & Accident Insurance

Reliance Standard Life Insurance Company  
P.O. Box 7818  
Philadelphia PA 19101  
800-644-1103

### Long Term Disability Plan (for Administrators Only)

The Paul Revere Life Insurance Company  
18 Chestnut Street  
Worcester MA 01608-1528  
800-799-4455

## Flexible Spending Accounts

The flexible spending accounts are administered by CIGNA HealthCare. Under the tax laws, participating employee contributions are treated as Stamford Public Schools contributions for the employees' benefit and are intended to be non-taxable to the participating employees when used for eligible expenses.

CIGNA HealthCare has the discretionary authority to determine all benefits in accordance with IRS regulations that govern flexible spending accounts. Stamford Public Schools sets up a reserve on its books for the amount directed to the participating employee's flexible spending account. Stamford Public Schools acknowledges its obligation to make payments due and the participating employee has all the rights of a general creditor.

## Claiming Health Benefits

Usually, claims for benefits will be made by your providers. However, occasionally you may be required to file a formal claim for benefits. The procedures for filing a formal claim for benefits are set forth below. For purposes of these procedures, in the case of insured programs "benefits administrator" means the insurer or its delegates. In the case of programs that are not insured, "benefits administrator" means the plan administrator or its delegate. See the previous Plan Funding section to determine if a program is insured.

Stamford Public Schools, as plan administrator, or its delegate, has the exclusive discretionary authority to construe and to decide all questions of eligibility for benefits and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. As the plan administrator, Stamford Public Schools has periodically exercised its authority to delegate discretionary authority in contracts, letters and various plan documents, e.g., to the various claims or contract administrators and insurers.

## Filing a Medical, Dental or Prescription Drug Claim – Post-Service

If you use a medical provider that is in Anthem Blue Cross and Blue Shield's Century Preferred network or a pharmacy in Medco's network and you use the applicable ID card, then you don't need to file a claim. If you don't use your ID card, you must submit a claim to the applicable benefits administrator. You will also need to submit a claim to CIGNA Dental whenever you obtain dental care.

To make a claim for benefits, you must submit a claim form to the benefits administrator at the address shown earlier in the Medical and Prescription Drugs sections. You will receive a written notice from the benefits administrator or its delegate regarding your claim within 30 days of its receipt by the benefits administrator. If an extension of time to process your claim is required because of reasons beyond the control of the benefits administrator, you will receive written notice of the need for an extension before the end of the 30-day period, explaining the reasons for the delay. The extension period will be 15 days from the end of the initial period. If the reason for the extension is due to your failure to provide necessary information, the determination period will be tolled from the date the benefits administrator gives you notice that additional information is necessary until the earlier of the date you respond to the request for additional information or 45 days from the date you receive the request. You must provide any additional information needed to process your claim within 45 days of receiving the request for additional information. If you don't provide the needed information within the 45-day period, your claim will be denied if there is insufficient information to decide the claim. A denial notice will explain the reason for the denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedure.

If your health benefits are provided through an HMO, contact the HMO for information on how to file a claim for benefits.

## Appealing a Denied Post-Service Medical, Dental or Prescription Drug Claim

If the benefits administrator denies all or part of your claim, you or your beneficiary will be notified in writing. Claim denials include denials for pre-certification requests (see next section). This notice will include:

- Specific reasons why the claim was denied and reference to the specific plan provision(s) on which the denial is based;
- Description of any additional information needed to perfect the claim, and an explanation of why such information is necessary;
- A statement of any internal rule, protocol, or guideline if relied upon to make the denial;
- If a denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that you may receive such explanation free of charge upon request; and
- An explanation of how to appeal for reconsideration of the benefits administrator's decision.

If you disagree with the benefits administrator's decision, you must submit your written appeal to the benefits administrator within 180 days after you receive the claim denial. After the benefits administrator receives your written request appealing the initial determination, a full and fair review of your claim will be conducted. You will be notified in writing of a decision within 30 days, after the benefits administrator receives your written request for review.

If you are not satisfied with the first level appeal decision, you may request a second level appeal. Your second level appeal request must be submitted to the benefits administrator within 60 days of your receipt of the first level appeal decision. A second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision. If your second level appeal is denied, or if you do not receive a response within 30 days, you have exhausted the plan's appeals process. If your denied claim is through an HMO, the HMO will tell you how to appeal it.

Also available to you are services through the State of Connecticut's Office of the Healthcare Advocate. More information about how the State of Connecticut's Office of the Healthcare Advocate may assist you with appeal/grievance procedures may be obtained online at [www.ct.gov/oha](http://www.ct.gov/oha) or by calling 866-HMO-4446.

## Prior Authorization

Claims for prior authorization under the medical plans administered by Anthem BCBS are also subject to the claims and appeals process. You must call Anthem BCBS' Member Services at 1-800-233-4947 to request prior authorization for certain medical services or treatments. You must also call Anthem BCBS' Member Services to request prior authorization for mental health and/or substance abuse services or treatments.

## Non-Urgent Care

You will receive a written notice from the benefits administrator regarding your prior authorization within 15 days of its receipt by the benefits administrator. If an extension of time to process your

claim is required because of reasons beyond the control of the benefits administrator, you will receive written notice of the need for an extension before the end of the 15-day period, explaining the reasons for the delay. The extension period will be 15 days from the end of the initial period. If the reason for the extension is due to your failure to provide necessary information, the determination period will be tolled from the date the benefits administrator gives you notice that additional information is necessary until the earlier of the date you respond to the request for additional information or 45 days from the date you receive the request. You must provide any additional information needed to process your prior authorization within 45 days of receiving the request for additional information. If you don't provide the needed information within the 45-day period, your claim will be denied if there is insufficient information to decide the claim. A denial notice will explain the reason for the denial, and provide the claim appeal procedure.

### **Urgent care**

You will receive notice of the benefit determination as soon as possible, taking into account the seriousness of your condition, but in any event within 72 hours after the benefits administrator receives your prior authorization request. If your prior authorization was properly filed and denied, a written denial notice will be provided to you within three days.

If your prior authorization request is filed improperly, the benefits administrator will notify you of the improper filing and how to correct it within 24 hours after the prior authorization request was received. If additional information is needed to process the prior authorization, the benefits administrator will notify you of the information needed within 24 hours after the prior authorization request was received. You will then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after the earlier of:

- The benefits administrator is in receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.
- A denial notice will explain the reason for denial, and provide the appeal procedures.

### **Concurrent Care**

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and you request to extend the treatment in an urgent care circumstance, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The benefits administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new prior authorization and decided according to non-urgent care or urgent care timeframes, whichever applies.

### **Appealing a Denied Prior Authorization**

If the benefits administrator denies all or part of your request for prior authorization, you or your beneficiary will be notified in writing. This notice will include:

- Specific reasons why the prior authorization was denied and reference to the specific plan provision(s) on which the denial was based;
- Description of any additional information needed to perfect the claim, and an explanation of why such information is necessary;

- A statement of any internal rule, protocol, or guideline if relied upon to make the denial;
- If a denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that you may receive such explanation free of charge upon request; and
- An explanation of how to appeal for reconsideration of the benefits administrator's decision.

### **Non-Urgent Care**

If you disagree with the benefits administrator's decision, you must submit your written appeal to the benefits administrator within 180 days after you receive the denial. After the benefits administrator receives your written request appealing the initial determination, a full and fair review of the denial will be conducted. You will be notified in writing of a decision within 15 days after the benefits administrator receives your written request for review.

If you are not satisfied with the first level appeal decision, you may request a second level appeal. Your second level appeal request must be submitted to the benefits administrator within 60 days of your receipt of the first level appeal decision. A second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review. If your second level appeal is denied or if you do not receive a response within 15 days, you have exhausted the plan's appeals process.

### **Urgent care**

The appeal does not need to be submitted in writing. You or your physician should call the benefits administrator as soon as possible. The benefits administrator will provide you with a written determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

## **Filing a Flexible Spending Account Claim**

You must submit a claim for all medical, dental, prescription drug and dependent care expenses. To make a claim for benefits, you must file a written claim with CIGNA HealthCare, the benefits administrator, using the claim form found online at [www.stamfordpublicschools.org](http://www.stamfordpublicschools.org).

You will receive a written notice from the benefits administrator or its delegate regarding your claim within 30 days of its receipt by the benefits administrator. If an extension of time to process your claim is required because of reasons beyond the control of the benefits administrator, you will receive written notice of the need for an extension before the end of the 30-day period, explaining the reasons for the delay. The extension period will be 15 days from the end of the initial period. If the reason for the extension is due to your failure to provide necessary information, the determination period will be tolled from the date the benefits administrator gives you notice that additional information is necessary until the earlier of the date you respond to the request for additional information or 45 days from the date you receive the request. You must provide any additional information needed to process your claim within 45 days of receiving the request for additional information. If you don't provide the needed information within the 45-day period, your claim will be denied if there is insufficient information to decide the claim. A denial notice will explain the reason for the denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedure.

### **Appealing a Denied Flexible Spending Account Claim**

If the benefits administrator denies all or part of your claim, you or your beneficiary will be notified in writing. This notice will include:

- Specific reasons why the claim was denied and reference to the specific plan provision(s) on which the denial is based;
- Description of any additional information needed to perfect the claim, and an explanation of why such information is necessary;
- A statement of any internal rule, protocol, or guideline if relied upon to make the denial; and
- An explanation of how to appeal for reconsideration of the benefits administrator's decision.

If you disagree with the benefits administrator's decision, you must submit your written appeal to the benefits administrator within 180 days after you receive the claim denial. After the benefits administrator receives your written request appealing the initial determination, a full and fair review of your claim will be conducted. You will be notified in writing of a decision within 30 days, after the benefits administrator receives your written request for review.

If you are not satisfied with the first level appeal decision, you must request a second level appeal. Your second level appeal request must be submitted to the benefits administrator within 60 days of your receipt of the first level appeal decision. A second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision. If your second level appeal is denied, or if you do not receive a response within 30 days, you have exhausted the plan's appeals process.

## Filing a Disability Claim – Administrators Only

To make a claim for disability benefits, you must file a claim with The Paul Revere Life Insurance Company, the benefits administrator.

You will receive a written notice from the benefits administrator or its delegate regarding your claim within 45 days of its receipt by the benefits administrator. If an extension of time is required to process your claim, you will receive written notice of the need for an extension before the end of the 45-day period, explaining the reasons for the delay. The 45-day response period may be extended by two additional 30-day periods (with prior notice) for a total of 105 days. If the reason for the extension is your failure to provide necessary information to decide the claim, the determination period will be tolled from the date notice of insufficiency is given, until you respond to the notice. You will have 45 days within which to provide the specified information.

## Appealing a Denied Disability Claim

If the benefits administrator denies all or part of your claim, you will be notified in writing. This notice will include:

- Specific reasons why the claim was denied;
- Specific references to applicable provisions of the plan document or other relevant records or papers, and information regarding where you may see them;
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary;
- Any guidelines that were relied upon in issuing the denial or a statement that such guidelines will be provided to you free of charge upon request; and
- Information as to the steps to be taken if you wish to appeal the determination, including your right to submit written comments and have them considered, and your right to review (or request at no charge) relevant documents and other information.

If you disagree with the benefits administrator's decision, you have 180 days to request a review. Your appeal must be submitted in writing within 180 days after the benefits administrator's initial notice of adverse benefit determination, or else you will lose the right to appeal your denial. Your

written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents you feel support your claim. You may also ask additional questions and make written comments, and you may review (on request at no charge) documents and other information relevant to your appeal.

The benefits administrator will review and decide your appeal within a reasonable time not longer than 45 days after it is submitted and will notify you of the decision in writing. If the benefits administrator determines that an extension to process the appeal is necessary due to special circumstances, the benefits administrator can extend the 45-day response period for up to 45 days by notifying you, prior to the termination of the initial 45-day period, of the circumstances requiring the extension and the date by which it expects to render a decision. If the reason for the extension is your failure to provide necessary information, the determination period shall be tolled until the earlier of the date you respond to the request for additional information or 45 days from the date you receive the request. If you don't provide the needed information within the 45-day period, your claim will be denied if there is insufficient information to decide the appeal.

The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate. In the case of an appeal involving medical judgment, the benefits administrator will secure independent medical or other advice and require such other evidence, as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse determination on review setting forth:

- Specific reasons for the denial;
- Specific plan provisions on which the decision is based;
- If the benefits administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol or similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and

Any claim that is subsequently reviewed by any entity other than the benefits administrator shall be conditioned on you having fully exhausted the rights and procedures described above and shall be reviewed solely on the basis of the information before the benefits administrator.

## **Filing a Life Insurance and/or an Accidental Death & Dismemberment Claim**

To make a claim for life insurance and/or accidental death & dismemberment (AD&D) benefits you will need to the Benefits Administration Office (203-977-4196 or 203-977-4773) as soon as is reasonably possible after the accident and/or death of the insured. After receiving a claim form from the Benefits Administration Office, you must return the completed claim form with the required proof to the Benefits Administration Office. The Benefits Administration Office will verify your insurance coverage and send the claim form and proof to The Reliance Standard Life Insurance Company (Reliance). When Reliance receives the claim form and proof, they will review the claim, and process it for approval (processing time 4-6 weeks). Upon a successful approval, Reliance will pay benefits subject to the terms and provisions of Stamford Public School's Group Policy.

# Life and/or AD&D Claims Appeal Process

## Initial Determination

After Reliance receives your claim, it will review your claim and notify you of its decision to approve or deny your claim. Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date Reliance received your claim, unless Reliance notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If Reliance denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Policy provision(s) on which the denial is based. If the claim is denied because Reliance did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Policy review procedures and time limits, including a statement of how to appeal the determination.

## Appealing the Initial Determination

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by Reliance. This request for review must be sent in writing to The Reliance Standard Life Insurance Company within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. If you do not file an appeal within the 60-day period, you will be deemed to have waived any right to appeal the denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believes the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deems appropriate. Upon your written request, Reliance will provide you free of charge with copies of relevant documents, records and other information.

Reliance will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date Reliance received your request for review, unless Reliance notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If Reliance denies the claim on appeal, it will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Policy provision(s) on which the denial is based, any voluntary appeal procedures offered by the Policy. Upon written request, Reliance will provide you free of charge with copies of documents, records and other information relevant to your claim.

## Reimbursing the Plan

If you or one of your dependents suffers a loss or injury caused by the actions or omissions of a third party, that third party may be responsible for paying your medical and dental expenses.

**For example, if you are injured in a car accident, the person who caused the accident is the "third party," and may be responsible for paying for your injury-related expenses.**

You will be required to provide information concerning any claim or lawsuit you or your dependents may have against a third party for injury caused by that party. You may be asked to

sign a repayment agreement as a condition for receiving benefits under the plan. If the agreement is not signed or you fail to cooperate with the benefits administrator, you will lose your medical benefits related to the accident.

**If you decide to sue the person who caused the accident, you must inform the Benefits Administration Office.**

If you receive any type of payment, reimbursement or legal recovery from the third party or an insurer, you are obligated to reimburse the plan for any expenses which the plan paid to you and/or your dependent(s) and for any related legal and collection costs the plan incurred.

**In the above example, if the plan paid for the medical expenses which you incurred as a result of the accident, and you later received money from the person who caused the accident, you must pay back the plan from the money paid by the person who caused the accident.**

Your obligation to reimburse the plan exists for any legal recovery that relates to an injury or illness covered by your benefits (including any amounts used to pay your legal fees), **even if you recover less than initially claimed (or less than your full loss) and even if the legal recovery is designated as not for medical expenses.**

## Right of Subrogation

The plan's right to receive any payment, reimbursement or recovery discussed above supercedes and has priority over your or your dependent's right to receive any payment, reimbursement or recovery. The plan expressly rejects and overrides any default rule that the plan does not have a right of subrogation until you or your dependent have been fully compensated.

## Limitations on Actions

You cannot bring any legal action against Stamford Public Schools or any claims administrator to recover reimbursement until you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Stamford Public Schools or any claims administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Stamford Public Schools or any claims administrator. You cannot bring any legal action against Stamford Public Schools or any claims administrator for any reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Stamford Public Schools or any claims administrator you must do so within three years of the date you are notified of our final decision on your appeal. Otherwise, you lose any rights to bring such an action against Stamford Public Schools or any claims administrator.

## Qualified Medical Child Support Orders

A "Qualified Medical Child Support Order" (QMCSO) is a medical child support order creating or recognizing your child's right to receive coverage under a medical plan established and maintained by Stamford Public Schools. Orders, which need to be qualified, should be sent to the Benefits Administration Office. Payments for coverage required by a QMCSO will generally be deducted from your pay.

## Information about Taxes

The plans described in this book provide benefits to eligible employees in accordance with federal law and governing documents. It is intended that the value of welfare plan coverage generally be non-taxable for federal income tax purposes where permissible under the tax code. Stamford Public Schools does not guarantee the tax consequences of plan participation and no one at Stamford Public Schools is authorized to give you tax advice. You are urged to consult with a tax advisor if you have any questions or concerns about your individual situation.