MIDDLEBURY
HEALTH AND WELFARE BENEFITS PLAN

Summary Plan Description

Retiree Version

Effective as of January 1, 2017
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INTRODUCTION

This Summary Plan Description ("SPD") is intended to provide you with an easily understandable description of the main provisions of the Middlebury Health and Welfare Benefits Plan ("Plan"). To serve this purpose, the SPD cannot explain all of the details of the Plan. **IF THERE ARE ANY INCONSISTENCIES BETWEEN THIS SPD AND THE PLAN DOCUMENT, THE PLAN DOCUMENT WILL GOVERN.** Separate benefit summaries, booklets or pamphlets (collectively, "Summaries") are attached to this SPD which describe the different benefits that are offered as part of the Plan. These Summaries are intended to be read with, and considered part of, this SPD. If you have questions or would like to see or obtain a copy of the Plan document, please contact the Office of Human Resources of your Employer.

This SPD is intended to primarily describe those Plan benefits available to Eligible Retirees. A separate SPD has been prepared that also describes benefits available to Eligible Employees.

I. GENERAL INFORMATION

1.1 **Plan Name and Effective Date.** The full name of the Plan is the Middlebury Health and Welfare Benefits Plan. This SPD reflects the terms of the Plan in effect as of January 1, 2017, unless otherwise noted.

1.2 **Plan Number.** The number assigned to the Plan is 501.

1.3 **Employer Information.**

   The President and Fellows of Middlebury College ("Employer")
   152 Maple Street, Suite 203
   Middlebury, Vermont 05753
   (802) 443-5465

   EIN: 03-0179298

1.4 **Plan Year.** The Plan Year is generally the period from January 1 through December 31. The Plan’s records are kept on a Plan Year basis.

1.5 **Plan Administrator.** The Plan Administrator is the Employer, or its designee, and may be contacted at the address and telephone number given above. The Employer is the "named fiduciary" for the Plan within the meaning of Section 402(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

   Although this SPD references benefits provided by your specific "Employer," the College is responsible for administration of the Plan.
1.6 **Agent for Service of Legal Process.** The designated agent for service of legal process is the Office of the General Counsel at the following address:

The President and Fellows of Middlebury College  
Office of the General Counsel  
Middlebury, Vermont 05753

Process may also be served upon the Plan Administrator.

1.7 **Type of Plan and Eligibility.** The Plan is an employee welfare benefit plan, within the meaning of Section 3(1) of ERISA, which offers the benefits described in Section 3.1 to eligible Retired Employees (as described in Section 2.1) and their beneficiaries. The Plan also offers certain benefits to Eligible Employees, which are described in a separate SPD.

1.8 **Discretion of Plan Administrator.** Notwithstanding any other provision in the Plan and this SPD, and to the full extent permitted by ERISA and the Code, the Plan Administrator (and its designees and representatives) has the discretionary authority to construe any uncertain or disputed term or provision in the Plan and this SPD. The Plan Administrator's exercise of this discretionary authority shall be binding and shall be given deference on any judicial (or other) review, to the fullest extent permitted by law. Notwithstanding the foregoing, to the extent an insurer exercises sole discretionary authority or discretionary responsibility over the benefit claims procedure, it shall be the only fiduciary for purposes of the Plan with authority and discretion to construe any uncertain or disputed term or provision in its contracts, booklets and certificates.

1.9 **COBRA Continuation Coverage.** Under a Federal law referred to as COBRA, your covered spouse and dependents, have the right, at your (or their) own expense, to continue coverage that otherwise would end for the Group Health Benefits described in 3.1(a) and the Vision benefits described in 3.1(b). These rules, which are very important for you, are explained in Article V. You may have other continuation coverage rights under state law. You should contact your Employer's Office of Human Resources for further information.

1.10 **Other Special Statutory Rules - HIPAA, FMLA and USERRA.** The usual rules of the Plan will be modified when and as applicable to comply with: (i) the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); (ii) the Family and Medical Leave Act of 1993 ("FMLA"); and (iii) the Uniform Services Employment and Reemployment Act of 1994 ("USERRA"); contact the Plan Administrator to obtain information about any of these rules.

*HIPAA Non-Discrimination Rules:* This Plan will not deny certain Group Health Benefits in accordance with the HIPAA non-discrimination rules.

*Privacy of Your Protected Health Information:* The Employer will use and disclose individually identifiable health information ("Protected Health Information" or "PHI") as defined in 45 C.F.R. Parts 160 and 164 and specifically 45 C.F.R. Section 164.504(f) (the
“HIPAA Privacy Rule”), only to perform administrative functions on behalf of the sponsored group health plan. The Employer will not use or disclose such information for any purpose other than as permitted to administer the Plan or as permitted by applicable law.

The group health plan shall disclose PHI to the Employer only upon receipt of the certification by the Employer that the plan document has been amended to incorporate the provisions herein. The Employer will ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information. The Employer will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans. The Employer will report to the group health plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for herein of which it becomes aware.

The Employer will make available PHI to the Plan for purposes of providing access to individual’s PHI in accordance with 45 CFR Section 164.524. The Employer will make available PHI to the Plan for amendment and incorporate any new amendments to PHI in accordance with 45 CFR Section 164.526 and shall make available PHI and any disclosures thereof to the Plan as required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528.

The Employer will make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rules and the Employer will notify the Plan of any such request by the Secretary prior to making such practices, books and records available. The Employer will, if feasible, return or destroy all PHI received from the Plan that it maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosures were made, except if such return or destruction is not feasible, and shall limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible.

The Employer will also ensure that only its employees or other persons within its control that participate in administering the Plan will be given access to PHI, including those employees or persons who receive PHI relating to Payment, Health Care Operations (as defined in the HIPAA Privacy Rules), or other matters pertaining to the Plan in the ordinary course of the business and perform Plan administration functions. The Employer agrees to demonstrate to the satisfaction of the Plan that it has put in place effective procedures to address any issues of noncompliance with the privacy rules described in this section by its employees or other persons within its control.

**HIPAA Privacy and Security Rules:** This Plan will protect individually identifiable health information as required by the “Administrative Simplification” provisions of the HIPAA regulations.
1.11 Right to Amend and Terminate Plan. The Employer expressly reserves the unqualified right to amend or terminate the Plan at any time and for any reason, including, but not limited to the right to change any benefit provisions and required premium contributions, deductibles and co-payments. Notwithstanding any other provision in the Plan or this SPD to the contrary, no participant, spouse, dependent or other beneficiary shall have any right to benefits under the Plan or SPD which in any way interferes with your Employer's right to terminate the Plan or amend the Plan. There are no contractual rights to benefits under the Plan. **YOUR EMPLOYER MAKES NO PROMISE TO CONTINUE PLAN BENEFITS IN THE FUTURE AND RIGHTS TO FUTURE BENEFITS DO NOT VEST.** In particular, termination of employment or retirement does not in any manner confer upon any Participant or other beneficiary any irrevocable right to continued benefits under the Plan.

1.12 Funding and Type of Administration. Group Health Benefits under the Plan (including dental benefits) are self-funded by the Employer, and administered pursuant to a contract the Employer has with CIGNA Health and Life Insurance Company (“CIGNA”). Participants are required to contribute toward the cost of Group Health Benefits, as specified on a schedule maintained by your Employer’s Office of Human Resources (“Human Resources”).

Vision benefits are provided pursuant to a contract the Employer has with Vision Service Plan Insurance company (“VSP”). Retirees pay the entire cost of coverage elected.

Additional benefits are available to Eligible Employees, as described in a separate SPD.

Specific eligibility for the above-mentioned benefits is set forth in Article II and the applicable documents for each individual benefit. A schedule of required contributions is available from Human Resources.

1.13 Information To Be Furnished. You are required to provide the Plan Administrator and its designee(s) with such information and evidence, and to sign such documents, as may reasonably be requested from time to time for the purpose of Plan administration. If not so provided or signed, the Plan Administrator or its designee(s) may deny benefits until the requested information, evidence, and/or documents is/are furnished. If any false or misleading information concerning the Plan or any Plan benefit is provided to the Plan Administrator or its designee(s) by you, a covered spouse, a covered eligible domestic partner, any individual with whom you have entered into a civil union or a covered dependent (collectively, “Covered Person”), or any person or entity acting on behalf of a Covered Person, the Plan Administrator (or, if applicable, a designee of the Plan Administrator) will have the discretionary authority, to the full extent permitted by law, to terminate the coverage of the Covered Person prospectively and to recoup, offset or otherwise recover any overpayment or other benefit that you, your covered spouse or your covered dependent received as a result of such false or misleading information. In the case of fraud or an intentional misrepresentation of material fact made by a Covered
Person, the Plan Administrator or its designee reserves the right to terminate a Covered Person’s coverage retroactively, to the extent permitted by law, and to recoup, offset or otherwise recover any overpayment or other benefit that the Covered Person received as a result of such fraudulent act or intentional misrepresentation.

The requirement to sign documents that may be reasonably requested by the Plan Administrator or its designee(s) includes, but is not limited to, the requirement to sign such documents as may be required to secure the Plan’s subrogation and reimbursement rights (these rights are explained more fully in the Summaries for the medical and dental benefits). In addition to the subrogation and reimbursement rights of the Plan described in the Summaries, any amounts subject to the Plan’s reimbursement rights that are recovered by a Covered Person from a third party will be considered Plan assets that must be repaid to the Plan, and the Covered Person will be considered a fiduciary with respect to those Plan assets. The failure of a Covered Person to repay such funds to the Plan will be considered a fiduciary breach, subject to the Plan’s right of relief under Sections 409(a) and 502(a) of ERISA.

1.14 Timely Claims. All claims for benefits must be submitted by the claims filing deadline specified under the rules for a particular benefit. If the applicable Summaries do not specify a filing deadline, then claims must be submitted within one year from the date the services relating to the claim were performed or the event that gave rise to the benefit occurred. This requirement may be waived by the Plan if, through no fault of the Participant or Beneficiary, the claim is filed after the deadline but is filed as soon as practicable and within a reasonable time period, given the particular circumstances.

A claimant may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Employer, or any other person, with respect to a claim for disability, medical, or other claims for benefits without first exhausting the Plan’s claims procedures. A claimant who has exhausted these procedures and is dissatisfied with the decision on appeal of a denied claim may bring an action under Section 502 of ERISA in an appropriate court to review the Plan Administrator’s decision on appeal, but only if such action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the decision on appeal.
II. ELIGIBILITY

2.1 **Am I eligible to participate in the Plan if I am retired?** You are generally eligible to participate in the Plan as an “Eligible Retiree” if you were an Eligible Employee (as that term is defined in the Plan) immediately prior to retirement from your Employer, and:

(a) you were employed by your Employer for ten consecutive years following the attainment of age forty-five in a “benefits eligible” position; or

(b) you were a Faculty Employee of your Employer, but resigned from a tenured position to take a part-time position, regardless of age or years of service.

Eligible Retirees may continue participation in the Plan upon retirement from the Employer for medical insurance, vision and dental insurance benefits only.

2.2 **Are my spouse, dependent(s), domestic partner or individual with whom I have entered into a civil union eligible for benefits under the Plan?** Your spouse, dependent(s), domestic partner (as determined by documents maintained by Human Resources) or any individual with whom you have entered into a civil union may be eligible for coverage under the specific benefit options you select to the extent they satisfy any additional eligibility requirements set forth for that specific benefit. Your spouse is a person who is legally married to you under state law, regardless of your place of domicile.

To enroll your domestic partner, you must have *either* registered your domestic partnership in a jurisdiction that authorizes such domestic partnership, or complete the forms required by your Employer.

Your domestic partner must be enrolled for coverage at the time you are first eligible for coverage under the Plan without a further waiting period. During any subsequent enrollment period your domestic partner (except a domestic partner registered in a jurisdiction that authorizes such domestic partnership, which will follow the same rules as spouses or civil union partners) will not be allowed to enroll for coverage under the Plan unless he or she has been identified as your domestic partner in the records of Human Resources for at least six months and he or she has lost coverage under another benefit plan OR he or she has been identified as your domestic partner in the records of Human Resources for at least six months prior to an open enrollment period.

**Please note:** The definition of who is your dependent may differ between the benefits provided under the Plan. Please refer to each specific benefit summary for the applicable dependent eligibility.

2.3 **When must I enroll for benefits?**
Eligible Retirees must be enrolled for benefits under the Plan immediately prior to your retirement. You may continue participation in the Plan immediately upon retirement by submitting an election form to the Office of Human Resources. You also may elect to enroll in the retiree benefits offered under the Plan even if you did not enroll in such benefits immediately following your retirement. However, in order to enroll at a later date, you must provide the Employer with acceptable evidence of other medical coverage during the period following your retirement from employment with the Employer to the date of your enrollment (e.g., proof of coverage through your spouse’s employer or Marketplace coverage). If you are enrolling in the Plan following the loss of such other medical coverage, you must request enrollment within 30 days of the coverage loss.

Special enrollment will be allowed if you are required to provide Plan coverage for a child pursuant to a “qualified medical child support order,” or as otherwise required by federal law.

You may not be enrolled under the Plan (i) both as an Eligible Employee or Eligible Retiree and at the same time as a spouse, dependent or other beneficiary, or (ii) as a spouse, dependent or other beneficiary of more than one participant.

2.4 What effect does entitlement to Medicare have on my Plan benefits? In general, Eligible Retirees who have not yet attained age 65 receive the same benefits and coverage as active employees. Eligible Retirees who are eligible for Medicare (either because they have attained age 65 or are disabled) receive benefits pursuant to the Medicare Carve-Out provisions of the Plan. Please refer to Article XI for more information regarding Medicare.

2.5 Am I able to convert my sick leave hours to pay for medical or dental coverage at retirement?

Eligible Retirees may convert their Sick Leave Reserve (“SLR”) at retirement, as described in this Section 2.5.

At retirement, accumulated SLR hours will convert to insured days (weekends and the holidays listed in the Employee Handbook will not count) at a conversion rate of 7.75 hours per day. For each insured day, the Employer will pay 100% of the premium to continue the medical and/or dental benefits for any Covered Person until the end of the month in which the last SLR day is used. The Employer will pay the cost of the retiree medical and dental for the number of insured days. At the end of the insured days, a Covered Person will be eligible to continue the retiree medical and/or dental insurance at his or her own expense.

Example: If the number of SLR days is thirty (30) and you retire on 7/1/17, the converted sick leave would run out on 8/12/17. Therefore, the insurance would continue until 8/30/17.
There is no cash conversion of SLR.

2.6 **When will my participation in the Plan terminate?** Participation in the Plan generally will terminate when the first of the following events occurs: (a) the date the Plan is terminated (b) the date you are no longer an Eligible Retiree, (c) the date you revoke an election form, (d) the first day for which any required contributions are not paid, or (e) the date otherwise provided in the documents for a specific benefit.

For your spouse, dependent(s), domestic partner or individual with whom you have entered into a civil union, participation will also end upon the date they no longer satisfy the eligibility requirements under the Plan. You are required to notify Human Resources within 30 days of the date that your spouse, dependent(s), domestic partner or individual with whom you have entered a civil union no longer satisfies the Plan’s eligibility requirements (e.g., due to divorce, termination of domestic partner status or loss of dependent child status).

In certain circumstances, covered individuals will have the right to elect continuing coverage under a federal law known as "COBRA," after your participation in the Plan terminates (see Section 1.9 above and Article V). You may also have other continuation of coverage rights, and you should contact Human Resources for further information.

III. **BENEFITS AND CONTRIBUTIONS**

3.1 **What benefits are offered by the Plan to Eligible Retirees?**

(a) **Group Health Benefits.**

Your Employer offers medical and dental insurance benefits (collectively, "Group Health Benefits") in accordance with the general terms stated in the attached Appendix C and Appendix D, respectively. Summaries of the different Group Health Benefits have been attached to this SPD, and additional copies may be obtained by contacting Human Resources. Contribution requirements are described in Appendix B.

The terms and conditions of these different plans, including but not limited to contracts and policies with insurers or third-party administrators, determine the benefits payable and the other conditions of coverage. The provisions of these documents, as amended from time to time, are incorporated by reference in the Plan and this SPD and are available for your inspection in Human Resources.

(b) **Vision Benefits.**

Your Employer offers vision benefits in accordance with the terms stated in Appendix E and the remainder of this SPD. A summary of the vision benefits has been attached as
Appendix E of this SPD, and additional copies may be obtained by contacting Human Resources. Contribution requirements are described in Appendix B.

The terms and conditions of these benefits, including, but not limited to, contracts and policies with insurers, determine the benefits payable and the other conditions of coverage (for example, the definition of an Eligible Retiree and coverage limitations). The provisions of these documents, as amended from time to time, are incorporated by reference in the Plan and this SPD and are available for your inspection in Human Resources.

3.2 How is the cost of medical, dental and vision Plan benefits paid for by Eligible Retirees? Eligible Retirees are generally required to pay the entire cost of the coverage elected, unless eligible for participation in some other program sponsored by the Employer. Please refer to Appendix B for a description of the cost sharing exceptions that may apply for certain Eligible Retirees. All retirees pay the full cost of the vision insurance.

3.3 Is medical coverage provided under the Plan coordinated with other coverage? Medical coverage provided by this Plan is coordinated with coverage available under another medical benefits program. The purpose of coordination of benefits is to avoid both programs paying medical benefits for the same services. When an individual has medical coverage under this Plan and another medical plan, the individual has “primary” and “secondary” coverage. The program that is required to pay its benefits first is considered “primary.” The program that pays its benefits second is considered “secondary.” Any coordination of benefits with respect to the Plan will be done in accordance with the rules described in Appendix F.

IV. ELECTIONS

4.1 When and how do I elect Retiree Benefits under the Plan? When you first become an Eligible Retiree, you may elect the benefits that you want by submitting the designated election form to your Employer’s Office of Human Resources within 30 days of the end of your active employment.

4.2 When does my election become effective? An election of benefits is generally made prior to the first day of coverage, and is effective as of the first day of the coverage period.

4.3 What happens if I do not timely return an election form? If you fail to return your election form when you first become eligible to participate in the Plan as a retiree, you will not be eligible to enroll in the retiree benefits under the Plan unless you have a “Change In Family Status,” as described in Section 4.4 below.

4.4 May I change an election after I have enrolled in the Retiree Benefits under the Plan? You generally are not allowed to add a spouse, dependent, domestic partner or
individual with whom you have entered into a civil union once you have enrolled. However, you may change your election to add a spouse, dependent, domestic partner or individual with whom you have entered into a civil union after you have enrolled, if such a change is consistent with IRS rules that apply to changes in pre-tax premium elections, as described in the “Change In Family Status” section below (provided the change is also permitted by the Group Health Benefit). If you wish to make a change, be sure to ask Human Resources for the Plan's complete procedures that implement these IRS rules, if you have questions after reading the following summary. **You must make your new election in writing within 30 days of the occurrence that permits the change. As a Participant in this Plan you must notify Human Resources of any change in family status affecting your own, or a dependent’s, eligibility for benefits. Failure to do so can result in serious consequences including, but not limited to, the requirement to maintain your current election for the remainder of the applicable Period of Coverage, even if your coverage is reduced based on a change in family status (e.g., from family to single), AND/OR the requirement to repay claims that were paid on behalf of an individual who did not meet the definition of dependent under the Plan. These requirements will apply regardless of whether your change in family status involves a spouse, dependent, domestic partner, or individual with whom you have entered into a civil union.**

Additionally, if you failed to enroll in the retiree benefits offered under the Plan, you may enroll in the Plan at a later date provided you have a qualifying “Change In Family Status” that is consistent with your late enrollment, as described below.

**Cancellation of Coverage:** You may cancel coverage for yourself, your spouse and/or your dependents at any time. Additionally, your coverage (and coverage for your spouse and/or dependents) will automatically be cancelled if you fail to timely pay required premiums. **If coverage is cancelled, you, your spouse and/or your dependents will not be able to re-enroll in the retiree benefits under the Plan, unless otherwise required by federal law.**

**Special Enrollment Period for Medical Benefits under "HIPAA":** Under special HIPAA rules, you may have a 30-day special enrollment period to elect certain benefits, if you or a dependent (including your spouse) loses other coverage, or when an individual becomes your dependent through marriage, birth, adoption or placement for adoption.

In addition, a 60-day special enrollment period applies for the health benefits provided under the Plan if you or a dependent (including your spouse) loses Medicaid or State Children’s Health Insurance Program coverage, or if you or a dependent becomes eligible for assistance from the State to purchase coverage under the Plan.

The “Special Enrollment” provisions will also allow you to make changes to your election of benefits to cover your domestic partner or individual with whom you have entered into a civil union, to the extent allowed by law.
Changes In Family Status: You may change an election after you have elected retiree benefits due to one of the following changes in family status, provided the election change is consistent with the change in family status:

(i) A change in legal marital status;

(ii) A change in number of dependents;

(iii) A situation in which a dependent satisfies or ceases to satisfy eligibility requirements (for example, ineligibility due to age);

(iv) A change in residence (for you, a spouse or a dependent); or

(v) Any change in employment status, by you or another family member, with the consequence that you or that person becomes eligible, or ceases to be eligible, under an employer's cafeteria plan--or other plan offering benefits that could be offered through a cafeteria plan.

The “Change in Family Status” provisions will also allow you to make changes to your election of benefits for your domestic partner or individual with whom you have entered into a civil union, to the extent allowed by law.

Consistency Requirement: The consistency requirement for making an election change due to a change in family status normally is satisfied if, and only if, your election change is on account of and corresponds with a change in family status that affects eligibility for coverage under an employer's plan.

Cost or Coverage Changes for Benefits: You may change an election if the cost of a benefit changes, or if there is a change in benefit coverage. In part, these rules for benefits allow an appropriate election change when another family member is making an election change under an employer plan with a different period of coverage.

Changes Based on Medicare or Medicaid Entitlement: You may make a change that is appropriate to reflect the fact that an individual has gained or lost Medicare or Medicaid coverage.

Order Regarding Health Coverage for a Child: You also may make a change to comply with a court order regarding health coverage for a child, including an order entered as a qualified medical child support order under special ERISA rules (see Section 4.6 below). You may obtain a copy of the Plan's procedures from your Employer's Office of Human Resources.

4.5 Are there any circumstances in which I must choose benefits? The Plan is legally required to comply with the provisions of any qualified child medical support order ("QMCSO") that relates to Plan benefits. A QMCSO is a medical child support order that
may require a child (including a child born out of wedlock) to be covered by the Plan even if you would not otherwise have chosen to cover the child. You will be notified and provided with further information about the QMCSO rules if the Plan receives an order that applies to you. You may obtain a copy of the Plan’s QMCSO procedures from the Plan Administrator.

4.6 **What are the tax consequences of benefits offered under the Plan for your domestic partner or an individual with whom you have entered into a civil union?** The benefits provided to your domestic partner or an individual with whom you have entered into a civil union generally will be identical to those provided to your eligible spouse and eligible dependent child. In certain, limited circumstances, the Employer may contribute to the cost of your retiree benefits (these circumstances are described in Appendix B), including benefits provided to your domestic partner or an individual with whom you have entered into a civil union. However, under the Internal Revenue Code, only the cost of coverage for your eligible spouse and eligible dependent child generally is excluded from income and is exempt from income taxes. **Therefore, the value of Employer contributions towards the cost of coverage for a domestic partner or an individual with whom you have entered into a civil union is not excludable from income taxes unless, among other requirements, such domestic partner or individual with whom you have entered into a civil union is considered your “dependent,” as defined in Section 152 of the Code.**

If your domestic partner or individual with whom you have entered into a civil union is your dependent under the Code, and you have so informed your Employer by such means as is required by your Employer, you generally will be able to exclude from income the coverage for each eligible individual.

If your domestic partner or individual with whom you have entered into a civil union is not your dependent under the Code, you may still elect to provide such individual with benefits. However, payments for benefit coverage will be treated as follows:

- your Employer’s contribution for this coverage will be reported as additional compensation to you. Your Employer will be required to report applicable state and federal taxes based upon this additional compensation. (Please be advised that the value of coverage can be high. Therefore, the taxes you will be required to pay may be substantial.)

This information is not, nor is it a substitute for, professional tax advice. **The Employer urges you to consult with your tax advisors about the treatment of particular benefits on your tax return.**

**Please note:** In the event you notify the College or MIIS of an individual’s tax dependent status, such individual will be treated as your tax dependent on a prospective basis, unless HIPAA Special Enrollment rules apply.
V. COBRA HEALTH CONTINUATION COVERAGE

5.1 When will my participation in the Plan terminate?

THERE IS NO CONTRACTUAL RIGHT TO BENEFITS UNDER THIS PLAN AND FUTURE BENEFITS WILL NEVER VEST. In particular, retirement does not in any manner confer upon you, your spouse, your dependents or other beneficiaries any right to continued benefits under this Plan or any benefit options offered through the Plan, other than those specifically mentioned.

Generally, your participation in the Plan will end on the earlier of the date on which the Plan terminates, you cease to be an Eligible Retiree, or you fail to pay any required premiums. However, under federal law, continued health coverage may be available for your spouse and dependents ("Qualified Beneficiaries") at your (or their) own expense. These legal rights are known as "COBRA" rights and apply to group health plans.

The COBRA rights under the Plan are described in Section 5.2, below.

Note: Certain changes made by the Affordable Care Act may be relevant to your decision to elect COBRA.

First, there may be other coverage options for Qualified Beneficiaries other than COBRA coverage through the Plan. Beginning January 1, 2014, Qualified Beneficiaries will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, a Qualified Beneficiary may be eligible for a tax credit that lowers the monthly premium. Qualified Beneficiaries will be able to obtain information regarding applicable premiums, deductibles and out-of-pocket costs before making a decision to enroll in the Marketplace. Being eligible for COBRA does not limit eligibility for a tax credit through the Marketplace.

Second, health plans are prohibited from imposing preexisting condition exclusions beginning in plan years that commence on or after January 1, 2014. Because this requirement applies on a plan year basis, the exclusion may not apply immediately to all plans.

5.2 What are my COBRA rights under the Plan?

The term "COBRA" refers to the Consolidated Omnibus Budget Reconciliation Act of 1985, which, as amended, provides certain individuals with the rights to health continuation coverage described in this Section 5.2. A “Qualified Beneficiary” may elect “COBRA” coverage for either or both types of coverage upon the occurrence of a “Qualifying Event,” as explained below. Please note that although not required by law, your Employer will extend COBRA rights to your domestic partner or individual with
whom you have entered into a civil union in the same manner as such COBRA rights are extended to a spouse, as specified below.

(a) **Qualified Beneficiary.** A "Qualified Beneficiary" may be your spouse or dependent child (individually, "spouse" or "dependent child"; collectively "family members") who has health continuation rights with respect to an event that is a Qualifying Event.

- An individual normally must have coverage on the day before a Qualifying Event in order to be a Qualified Beneficiary. (For example, if the Qualified Beneficiary only has medical coverage, there is no COBRA election for dental coverage.)

- However, a child who is born to or placed for adoption with you during a period that you have COBRA coverage also is considered a Qualified Beneficiary. The COBRA period is measured from the same date as for other Qualified Beneficiaries with respect to the same Qualifying Event.

(b) **Qualifying Events For a Spouse To Elect COBRA Coverage.** Your spouse may elect health continuation coverage for himself or herself (and affected family members) if coverage would end due to one of the following Qualifying Events:

(i) your death;

(ii) your spouse's divorce or legal separation from you; or

(iii) your entitlement to Medicare.

(c) **Qualifying Events For a Dependent Child To Elect COBRA Coverage.** A dependent child may elect health continuation coverage if coverage otherwise would end due to any of the following five Qualifying Events:

(i) your death;

(iii) divorce or legal separation of you and your spouse;

(iv) your becoming entitled to Medicare; or

(v) loss of dependent child status under the terms of the Plan.

(d) **Notice Provisions; Election of Coverage:**

(i) You (or a family member or a legal representative) must inform your Employer’s Human Resource Office, in writing, within 60 days of the date that there is a divorce, a legal separation, or a loss of dependent child
status. The written notice must describe the particular Qualifying Event triggering the COBRA coverage (e.g., identify whether the Qualifying Event was due to divorce, legal separation, or loss of dependent status) and the date on which the event occurred. **If notice is not given in a timely manner, the right to COBRA health continuation coverage will be lost.**

(ii) Subject to the requirement in (i), when applicable, the affected Qualified Beneficiary or Beneficiaries will be notified of the right to choose COBRA health continuation coverage if a Qualifying Event occurs. The election for COBRA coverage must be made within 60 days from the later of the date of notification about COBRA or the date of loss of coverage. If an election is not made timely, coverage under the Plan will end and there will be no further COBRA rights.

(e) **Cost of Continuation Coverage.** A Qualified Beneficiary who chooses to continue health coverage may be required to pay up to, but not more than, 102 percent of the full cost to the Plan for the health coverage. The first premium payment must be made, with any payments owed from the date health coverage ended, within 45 days from the date the Qualified Beneficiary chooses to continue health coverage.

(f) **Length of Continuation Coverage:**

A Qualified Beneficiary may continue health coverage for up to 36 months in the event of death, divorce or legal separation, entitlement to Medicare, or ineligibility for dependent coverage.

(g) **Notice of Unavailability of Continuation Coverage.** If the Plan Administrator is notified of a Qualifying Event, second Qualifying Event, or a determination of disability by the Social Security Administration, regarding a Qualified Beneficiary, and the Plan Administrator determines that such individual is not entitled to the COBRA continuation coverage being requested, the Plan Administrator will notify the individual of that fact within 14 days of the receipt of a request for COBRA continuation coverage.

(h) **Termination of COBRA Continuation Coverage.** The COBRA coverage will end before the end of the applicable maximum time period in case of any of the following:

(A) your Employer ceases to provide health coverage to any employees or retirees;

(B) the premium is not paid on a timely basis under the COBRA rules;
(C) the Qualified Beneficiary becomes covered under another group health plan (not merely eligible) after the date on which COBRA coverage is elected for the Qualified Beneficiary; or

(D) the Qualified Beneficiary becomes entitled to Medicare (not merely eligible) after the date on which the COBRA coverage under this Plan is elected; or

(E) the maximum period of continuation coverage ends.

In the event that a Qualified Beneficiary’s COBRA continuation coverage is terminated prior to the end of the maximum period of continuation coverage applicable under COBRA, the Plan Administrator will notify the Qualified Beneficiary of the loss of COBRA continuation coverage as soon as is practicable following such determination.

VI. CLAIMS AND APPEAL PROCEDURES

6.1 How do I make a claim under the Plan? A claim for benefits under the Plan can be filed by a Plan Participant or beneficiary (a “claimant”), or by an authorized representative acting on behalf of the claimant, by contacting the insurer, HMO or claims administrator in the manner specified in the Summaries, booklets and/or contracts describing the coverage.

6.2 What are the procedures for Group Health Benefit claims? Each insurer, health maintenance organization and/or claims administrator for a Group Health Benefit will follow claims procedures that satisfy the requirements specified in this Section. For purposes of this procedure, the person who is responsible for making a claims decision is referred to as the “Claims Administrator.”

(a) Urgent Care. An “urgent care claim” is a claim for medical treatment or care that, if not provided quickly, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the case, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested.

A decision on an urgent care claim will be made within 72 hours after the request is received. If the request is incomplete, the claimant will be notified within 24 hours of the submission (and will be told of the specific information necessary to complete the claim). The claimant then has 48 hours after the notice is received (unless the insurer or Claims Administrator allows a longer period) to provide the additional information. A decision will be made by the later of (a) 48 hours after
the additional information is provided or (b) the expiration of the deadline to provide additional information.

An appeal of an adverse decision (denial) regarding an urgent care claim will be decided within 72 hours after the appeal request is filed.

(b) **Concurrent Care.** A "concurrent care claim" involves a decision by the Plan or an issuer to reduce or stop a course of treatment that has already begun.

Any reduction or termination of an ongoing course of treatment to be provided over a period of time or a specified number of treatments shall be treated as an "adverse benefit determination" (unless due to an amendment or termination of the Plan). The claimant will be notified of the decision to reduce or terminate the course of treatment in sufficient time to allow an appeal (and a determination on the appeal) to take place before the benefit is reduced or terminated.

(c) **Pre-Service Claims.** A "pre-service claim" is any claim for a benefit where the terms of the Plan require approval prior to obtaining medical care.

An initial decision on a pre-service claim must be made in a reasonable time, but no later than 15 days after the submission of the claim. This time period can be extended for an additional 15 days if the Claims Administrator determines that the extension is necessary due to matters beyond its control and notifies the claimant, before the end of the initial 15-day period, of the circumstances requiring the extension and the date by which a decision is expected.

If an extension is necessary to allow the claimant to submit additional information, the claimant will have 45 days from receipt of the notice to provide the information required.

(d) **Post-Service Claims.** A "post-service claim" is any claim that is not a "pre-service claim" (in other words, you do not need approval before obtaining medical care).

The claimant will be notified of any adverse benefit determination of a post-service claim within a reasonable time, but not later than 30 days after receipt of the claim. The period for a decision may be extended for an additional 15 days if the Claims Administrator determines that the extension is necessary due to matters beyond its control and notifies the claimant, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected.

If an extension is necessary to allow the claimant to submit additional information, the claimant will have 45 days from receipt of the notice to provide the information required.
(e) **Manner and Content of Notification of Benefit Determination.** The Claims Administrator will provide the claimant with a written or electronic notification of any adverse benefit decision. The notification will state, in a manner calculated to be understood by the claimant:

(i) The specific reason for the adverse determination;

(ii) Reference to the specific Plan provisions on which the determination is based;

(iii) information sufficient to identify the health claim (if applicable) involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(iv) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(v) A description of the Plan’s review procedures (including both the available internal appeals and external appeals process) and time limits (including a statement of the claimant’s right to bring a civil suit under Section 502(a) of ERISA following an adverse benefit determination on review);

(vi) a statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes; and

(vii) If the claim is an urgent care claim, a description of the expedited review process.

If an internal rule, guideline, protocol or other similar criterion (collectively, “Internal Rule”) was relied upon in making the adverse determination, the notification will contain the Internal Rule, or a statement that such an Internal Rule was relied upon in making the determination and that a copy of the Internal Rule may be obtained free of charge upon request. Further, if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notification will contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant’s medical circumstances), or a statement that such explanation will be provided free of charge upon request.
Appeal of an Adverse Determination. A claimant has 180 days following receipt of an adverse benefit determination to appeal that determination. (The appeal must be post-marked on or before the 180th day.) On appeal, a claimant has the opportunity to submit written comments and documents related to the claim for benefits and will be provided, upon request and free of charge, all documents, records and other information relevant to the claimant’s claim for benefits. A review will be conducted by a fiduciary who is neither the individual who made the initial determination nor a subordinate of that person. The review will take into account all information submitted by the claimant relating to the claim, regardless of whether such information was submitted in the initial benefit determination. If the adverse benefit determination was based, in whole or in part, on a medical judgment (including whether a particular treatment, drug, etc., is experimental, investigational or not medically necessary or appropriate) the reviewer will consult with an appropriate health care professional who is neither an individual who was consulted in connection with the initial determination nor a subordinate of that person. Any expert whose advice was obtained in connection with the adverse benefit determination will be identified to the claimant. Additionally, the Plan must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or issuer (or at the direction of the Plan or issuer) in connection with the claim, or any new rationale for issuing an adverse benefit determination, sufficiently in advance of the date that the notice of the final adverse benefit determination is required to give the claimant a reasonable opportunity to respond prior to that date.

6.3 What are the procedures for disability claims? A decision on a claim for benefits will be made no later than 45 days after receipt of the claim. This time period can be extended for two additional 30-day periods if, prior to the expiration of the determination period, the Claims Administrator determines that, due to matters beyond its control, a decision cannot be rendered within that determination period. If an extension of the initial 45-day claim period is necessary, the Claims Administrator will notify the claimant of the date it expects to render a decision. If a second 30-day extension becomes necessary, the Claims Administrator will inform the claimant of the standards on which entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

In any case where the Claims Administrator requests additional information, the claimant will have at least 45 days to provide the information.

If a disability claim is denied, a written request for review of the denial must be made within 180 days after receiving notice of the denial. A decision on appeal will be rendered within 45 days after the request for review. If an extension of time is required to process the claim, the Claims Administrator will notify the claimant in writing before the end of the initial 45-day period of the special circumstances requiring the extension and the date by which a decision is expected. The maximum extension period is 45 days. The
claimant has at least 45 days to provide any additional information requested by the Claims Administrator.

6.4 What are the procedures for all other claims? A decision on all other claims for benefits shall be made no later than 90 days after receipt of the claim. If the Claims Administrator determines that an extension of time for processing the claim is required, the claimant will receive written notice of the extension prior to the end of the initial 90-day period. The maximum extension period is an additional 90 days. The extension notice will describe the special circumstances requiring the extension and the date by which a decision is expected.

If a claim is denied, the claimant has 60 days to make a written appeal to the adverse decision. Written comments, documents, records and any other information related to the claim may be submitted. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

6.5 What are the requirements for notification of an adverse benefit determination on appeal? The Claims Administrator will provide the claimant with a written or electronic notification of any adverse benefit decision. The notification will state, in a manner calculated to be understood by the claimant:

(a) The specific reason(s) for the adverse determination;

(b) Reference to the specific Plan provisions on which the determination is based;

(c) Information sufficient to identify the health claim involved (if applicable) (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(d) 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 information relevant to the claimant's claim for benefits (whether information is relevant to a claim for benefits shall be determined pursuant to the applicable regulations);

(e) A description of the Plan's review procedures (including both the available internal appeals and external appeals process) and time limits;

(f) A statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review process;
(g) A description of the Plans review procedures and time limits (including a statement of the claimant’s rights to bring a civil suit under Section 502(a) of ERISA following an adverse benefit determination on review); and

In the case of a claim involving a group health or disability benefit:

- If an Internal Rule was relied upon in making the adverse benefit determination, the notification will contain the Internal Rule, or a statement that such an Internal Rule was relied upon, and that a copy of the Internal Rule will be provided free of charge to the claimant upon request.

- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion, the notification will contain either an explanation of the scientific or clinical judgment (applying the terms of the Plan to the claimant’s medical circumstances), or a statement that such an explanation will be provided free of charge upon request.

A final internal adverse benefit determination that benefits and/or coverage are not available under the Plan is final and binding on all interested parties.

6.6 Do I have the right to pursue an external review of my claim? The Patient Protection and Affordable Care Act of 2010 (“PPACA”) allows claimants to file an external appeal of a medical benefit claim following a final adverse benefit determination by the Plan, if the claim involves a medical judgment by the Plan or a rescission of coverage. External appeals are conducted by an independent review organization consisting of health professionals who have no connection to the Plan, the claimant’s health care provider, or the health care facility involved in the claimant’s care. A claimant will be notified about how to pursue an external appeal in the final adverse determination notification made by the Plan. An external review is only available following a final adverse determination by the Plan or if the claim meets the criteria for an expedited external review.

It is intended that these benefit claim procedures will comply with the benefit claim procedure requirements for non-grandfathered plans under the PPACA and its implementing regulations, and should be interpreted and applied to the full extent possible in a manner that is consistent with that intention. If it becomes necessary, prompt modification to these benefit claims procedures will be made to help ensure full compliance with the benefit claims procedure requirements of PPACA. If you have a question regarding the claims appeal process, please contact the applicable claims administrator or the Office of Human Resources.
VII. ERISA RIGHTS

As a Participant in the Plan you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

This includes the ability to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may have a right to continue health care coverage for yourself, your spouse or your dependents if there is a loss of Group Health Benefit and/or vision coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

VIII. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Plan provides Group Health Benefits in accordance with the applicable requirements of any "qualified medical child support order" as required under ERISA. In general, the term "qualified medical child support order" means a "medical child support order" which requires the Plan to provide a child of a participant with health coverage under the Plan where the child would not otherwise be covered, for instance, as a result of a parent’s divorce.

Group health plans and health insurers may not deny eligibility to enroll, renew or continue coverage in a plan, in order to avoid providing the above-described coverage provided by the law. Further, the law prohibits (i) penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care; or (ii) providing any incentive (monetary or otherwise) to induce the attending provider to provide care that would be inconsistent with the law.
The above-described coverage required by the law may only be subject to the annual deductibles and coinsurance provisions that apply to similarly benefits. Contact the Plan Administrator if you have questions.

IX. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under this Federal law, sometimes referred to as the "NMHPA," certain requirements are imposed on group health plans that provide maternity or newborn infant coverage. This includes the fact that the group health plans and health insurance issuers (such as insurance companies and HMOs) may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, the NMHPA does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

X. WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under this Federal law, group health plans that provide medical and surgical benefits for mastectomies must provide coverage in connection with the mastectomy, in the manner determined by the attending physician and the patient, for: (i) reconstruction of the breast on which the mastectomy was performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema.

Group health plans and health insurers may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. Further, the law prohibits: (i) penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care; or (ii) providing any incentive (monetary or otherwise) to induce the attending provider to provide care that would be inconsistent with the law.

The above-described coverage required by the law may only be subject to the annual deductibles and coinsurance provisions that apply to similar benefit.

XI. MEDICARE

General Medicare Benefit Information: Most retirees who are eligible for Medicare Part A benefits can receive such benefits at no cost because they or their spouse paid Medicare taxes
while working. Retirees age sixty-five (65) and over, who are required to pay for Medicare Part A coverage, may purchase Medicare Part A by making application and paying the full cost. Participation in Medicare Part B and Medicare Part D, is available to all employees age 65 and over who make application and pay the full cost of the coverage.

Retired Employees: Employees who enrolled in the Plan upon obtaining age 65 are automatically eligible to continue in the Plan provided they have met the definition of Eligible Retiree and their legal residence is in the United States. Due to the fact such Eligible Retirees are no longer in active employment, Medicare will be the primary payer of benefits and Plan benefits will be integrated on a carve-out basis.

Medicare Carve-Out: Retiree medical benefits are provided under a Medicare Carve Out plan, which generally offers protection for medical expenses not paid by Medicare. Medicare Carve Out complements Medicare by providing payment for expenses not paid by Medicare and is designed to provide protection against high medical bills. Payment is determined by the design of the medical insurance coverage.

Under Medicare Carve Out, this Plan will coordinate its benefits with those received by primary Medicare so that the total amount payable by Medicare and this Plan will be no more than 100 percent of the expenses incurred that are covered by this Plan. Any Covered Person (as defined in Section 1.13) who is eligible to enroll in Medicare must enroll in both Parts A and B of Medicare as soon as eligibility commences. The failure to enroll in Medicare Parts A and B as soon as eligibility commences will result in this Plan paying only those benefits it would have paid had the Covered Person enrolled in Medicare Parts A and B (please see the CIGNA booklet in Appendix C for additional information regarding Medicare). If a Covered Person who is disabled is initially denied Medicare coverage, he or she must attempt to subsequently enroll in Medicare at the following times: (i) at least one time per calendar year during each year following the calendar year in which the initial Medicare denial is made; and (ii) any time there is a material change in the individual’s health status that could affect the individual’s eligibility for Medicare. However, this section will not apply if your Employer is obligated by law to have this Plan pay its benefits before Medicare covers the health care services provided to the Covered Person.

Please note: Coordination between the Plan and Medicare Part D is different than coordination between the Plan and Medicare Parts A and B. Since the benefits provided to Eligible Retirees under the Plan include prescription drug benefits, if you are eligible for Medicare Part D and choose to enroll for Medicare Part D coverage, your benefits generally will not increase, but you will have an increase in cost due to the cost of your Medicare Part D premiums. As a result, there may not be any advantage to you enrolling for Medicare Part D coverage. However, if you choose to enroll in Medicare Part D, this Plan will pay secondary to Medicare Part D coverage. Please consider this carefully before deciding whether or not to enroll and pay for Medicare Part D coverage.
APPENDIX A

AFFILIATED EMPLOYERS PARTICIPATING IN THE PLAN

There are no Affiliated Employers currently participating in the Plan.
APPENDIX B

BENEFITS & CONTRIBUTIONS

Set forth below is a description of the benefits and contribution requirements for Eligible Retirees under the Plan.

I. GROUP HEALTH BENEFITS

Each Eligible Retiree may elect coverage under the Medical Insurance Plan and Dental Insurance Plan, in accordance with Appendices C and D respectively. Eligible Retirees are generally required to pay the entire cost of the coverage elected.¹

Changes to premiums, if any, are effective each July 1. The actual dollar amount of the required premiums for the coverage elected will be communicated to Participants prior to July 1. In addition, Plan changes may require contribution rate changes at other times during the Plan Year which will be communicated to Participants periodically. These communications are hereby incorporated by reference and made a part of this Plan.

II. VISION BENEFITS

Eligible Retirees may elect Vision Benefits, in accordance with Appendix E. Eligible Retirees are generally required to pay the entire cost of the coverage elected.

¹ In some instances, for some “grandparented” Eligible Retirees, the cost of coverage selected may be shared between the Employer and the Eligible Retiree. The list of “grandparented” Eligible Retirees is maintained in the Employer’s Office of Human Resources. For those Eligible Retirees not currently paying 100% of the cost of coverage, such costs are expected to increase by the regular annual premium increase plus 6% each year, but in no event will increase greater than 25% per year. Failure to pay the required premiums in a timely manner will result in termination of coverage. Also, the Employer has on occasion offered special retirement incentive programs which may include some employer-paid premiums. Retirees in these programs have written agreements with the Employer regarding these benefits; other retirees are not eligible.

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APPENDIX C

MEDICAL PLAN
Middlebury

PREFERRED PROVIDER MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2017

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This document printed in April, 2017 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
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Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY MIDDLEBURY WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

HC-N071
Explanation of Terms
You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

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

When you select a Participating Provider, the cost for medical services provided will be less than when you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or in an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well being of our members. We may also arrange for the reimbursement of all or a portion of the cost of services.

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provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

Care Management and Care Coordination Services
Your plan may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing participants with certain care management and care coordination services to facilitate achievement of these goals. Reimbursement is provided at 100% for these services when rendered by designated health care professionals in these collaborative arrangements.

Important Notices
Direct Access to Obstetricians and Gynecologists
You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Important Information
Rebates and Other Payments
Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals and Prescription Drug Products included on the Prescription Drug List. These rebates or remuneration are not obtained on you or your Employer’s or plan’s behalf or for your benefit. Cigna, its affiliates and the plan are not obligated to pass these rebates on to you, or apply them to your plan’s Deductible if any or take them into account in determining your Copayments and/or Coinsurance. Cigna and its affiliates or designees, conduct business with various pharmaceutical manufacturers separate and apart from this plan’s Medical Pharmaceuticals and Prescription Drug Product benefits. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this plan. Cigna and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications
At various times, Cigna or its designee may send mailings to you or your Dependents or to your Physician that communicate a variety of messages, including information about Medical Pharmaceuticals and Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you or your Dependents, at your discretion, to purchase the described Medical Pharmaceuticals and Prescription Drug Products at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Cigna its affiliates and the plan are not responsible in any way for any decision you make in connection with any coupon, incentive, or other offer you may receive from a pharmaceutical manufacturer or Physician.

If Cigna determines that a Pharmacy, pharmaceutical manufacturer or other third party is or has waived, reduced, or forgiven any portion of the charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Prescription Drug Product without Cigna’s express consent, then Cigna in its sole discretion shall have the right to deny the payment of plan benefits in connection with the Prescription Drug Product, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the Pharmacy, pharmaceutical manufacturer or other third party represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by the plan.

Discrimination is Against the Law
Cigna, in its role as benefits administrator, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or
sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with Cigna, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Customer Service/Member Services at the toll-free phone number shown on your ID card, and ask an associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address: Cigna, Nondiscrimination Complaint Coordinator, P.O. Box 188016, Chattanooga, TN 37422.

If you need assistance filing a written grievance, please call the toll-free phone shown on your ID card or send an email to ACAGrievance@cigna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; or by phone at 1-800-368-1019, 800-537-7697 (TDD).


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Proficiency of Language Assistance Services

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

Spanish

ATENCIÓN: tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1-800-244-6224 (los usuarios de TTY deben llamar al 711).
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 YOUR CIGNA CLAIM OFFICE.
- YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our 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.

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period once you meet the definition in section 2.1.

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.
Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Eligibility for Dependent Insurance
You will become eligible for Dependent insurance on the later of:
- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period
Initial Employee Group: None.
New Employee Group: First of the month coincident with or next following your employment, or your classification as an Eligible Employee.

Classes of Eligible Employees
Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance
Employees can be effective retroactively to their date of eligibility assuming they enroll within 30 days and were actively employed on their eligibility date.

Dependent Insurance
For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance
Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Exception for Newborns
Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Insurance no later than 30 days after his birth. If you do not elect to insure your newborn child within such 30 days, coverage for that child will end on the 30th day. No benefits for expenses incurred beyond the 30th day will be payable.
## Preferred Provider Medical Benefits

### The Schedule

**For You and Your Dependents**

Preferred Provider Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Preferred Provider Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible or Coinsurance.

When you receive services from an In-Network Provider, remind your provider to utilize In-Network Providers for x-rays, lab tests and other services to ensure the cost may be considered at the In-Network level.

**Coinsurance**

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

**Deductibles**

Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

**Out-of-Pocket Expenses - For In-Network Charges Only**

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in the Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

**Out-of-Pocket Expenses - For Out-of-Network Charges Only**

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%:

- Coinsurance.
- Plan Deductible.

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Non-compliance penalties.
- Provider charges in excess of the Maximum Reimbursable Charge.

### Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums will cross-accumulate (that is, In-Network will accumulate to Out-of-Network and Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) also cross-accumulate between In- and Out-of-Network unless otherwise noted.

### Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.
# Preferred Provider Medical Benefits

## The Schedule

**Assistant Surgeon and Co-Surgeon Charges**

**Assistant Surgeon**

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

**Co-Surgeon**

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td></td>
<td>Unlimited</td>
</tr>
<tr>
<td>The Percentage of Covered Expenses the Plan Pays</td>
<td>80%</td>
<td>80% of the Maximum Reimbursable Charge</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Maximum Reimbursable Charge</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Reimbursable Charge is determined based on the lesser of the provider’s normal charge for a similar service or supply; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A percentage of a schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:</td>
<td></td>
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</tr>
<tr>
<td>• the provider’s normal charge for a similar service or supply; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> The provider may bill you for the difference between the provider’s normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles and coinsurance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Some providers forgive or waive the cost share obligation (e.g. your deductible and/or coinsurance) that this plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this plan. For more details, see the Exclusions Section.</td>
<td>Not Applicable</td>
<td>200%</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>-------------------------------------------</td>
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<td>-----------------------------------</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$300 per person</td>
<td>$300 per person</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$900 per family</td>
<td>$900 per family</td>
</tr>
<tr>
<td>Family Maximum Calculation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Calculation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family members meet only their</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>individual deductible and then their</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>claims will be covered under the plan</strong></td>
<td></td>
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<tr>
<td><strong>coinsurance; if the family deductible</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>has been met prior to their individual</strong></td>
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</tr>
<tr>
<td><strong>deductible being met, their claims</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>will be paid at the plan coinsurance.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,100 per person</td>
<td>$1,100 per person</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$3,300 per family</td>
<td>$3,300 per family</td>
</tr>
<tr>
<td>Family Maximum Calculation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Calculation</td>
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<td></td>
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<tr>
<td><strong>Family members meet only their</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>individual Out-of-Pocket and then</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>their claims will be covered at 100%</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>if the family Out-of-Pocket has been</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>met prior to their individual Out-of-</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pocket being met, their claims will</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>be paid at 100%.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
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<tr>
<td>--------------------------------------------</td>
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<tr>
<td><strong>Physician's Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician's Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician's Office Visits</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Consultant and Referral Physician's Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong></td>
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<tr>
<td>OB/GYN providers will be considered either as a PCP or Specialist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surgery Performed in the Physician's Office</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Second Opinion Consultations</strong> (provided on a voluntary basis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician's Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician's Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Allergy Treatment/Injections</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician's Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician's Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Allergy Serum (dispensed by the Physician in the office)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Medical Telehealth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>80%</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>Specialty Care Physician</td>
<td>80%</td>
<td>In-Network coverage only</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
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<td>------------------------------------------</td>
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<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
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<tr>
<td>Note:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Preventive Care - all ages</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Immunizations - all ages (includes travel immunizations)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Mammograms, PSA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care Related Services (i.e. “routine” services)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Diagnostic Related Services (i.e. “non-routine” services)</td>
<td>Subject to the plan’s x-ray benefit &amp; lab benefit; based on place of service</td>
<td>Subject to the plan’s x-ray benefit &amp; lab benefit; based on place of service</td>
</tr>
<tr>
<td><strong>Inpatient Hospital - Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-Private Room and Board</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td></td>
<td>Limited to the semi-private room negotiated rate</td>
<td>Limited to the semi-private room rate</td>
</tr>
<tr>
<td>Private Room</td>
<td>Limited to the semi-private room negotiated rate</td>
<td>Limited to the semi-private room rate</td>
</tr>
<tr>
<td>Special Care Units (ICU/CCU)</td>
<td>Limited to the negotiated rate</td>
<td>Limited to the ICU/CCU daily room rate</td>
</tr>
<tr>
<td><strong>Outpatient Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Physician’s Visits/Consultations</strong></td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td><strong>Inpatient Professional Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Radiologist, Pathologist, Anesthesiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit Highlights</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td><strong>Outpatient Professional Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Radiologist, Pathologist, Anesthesiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Facility or Outpatient Facility</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the UC visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the UC visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER visit</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td><strong>Inpatient Services at Other Health Care Facilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Calendar Year Maximum: 120 days combined</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Laboratory Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient Hospital Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Independent Lab Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Benefit Highlights</td>
<td>In-Network</td>
<td>Out-Of-Network</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Radiology Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient Hospital Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td><strong>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td><strong>Outpatient Short-Term Rehabilitative Therapy and Chiropractic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary Rehab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Therapy (includes Chiropractors)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massage Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Includes Speech, physical, and/or occupational therapy for the treatment of Autism Spectrum Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlimited (includes outpatient private nursing when approved as Medically Necessary)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan deductible, then 80%</td>
<td></td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Benefit Highlights</td>
<td>In-Network</td>
<td>Out-Of-Network</td>
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<tr>
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</tr>
<tr>
<td><strong>Hospice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>(same coinsurance level as Home Health Care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bereavement Counseling</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services provided as part of Hospice Care</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Services provided by Mental Health Professional</td>
<td>Covered under Mental Health Benefit</td>
<td>Covered under Mental Health Benefit</td>
</tr>
<tr>
<td><strong>Medical Pharmaceuticals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Home Care</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Benefit Highlights</td>
<td>In-Network</td>
<td>Out-Of-Network</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Maternity Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Visit to Confirm Pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB/GYN providers will be considered either as a PCP or Specialist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>All subsequent Prenatal Visits, Postnatal Visits and Physician’s Delivery Charges (i.e. global maternity fee)</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Physician’s Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Delivery - Facility (Inpatient Hospital, Birthing Center)</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td><strong>Abortion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes elective and non-elective procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Benefit Highlights</td>
<td>In-Network</td>
<td>Out-Of-Network</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
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<td>----------------</td>
</tr>
<tr>
<td><strong>Women's Family Planning Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits, Lab and Radiology Tests and Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician’s office.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Specialty Care Physician</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Surgical Sterilization Procedures for Tubal Ligation (includes reversals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Men's Family Planning Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits, Lab and Radiology Tests and Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Surgical Sterilization Procedures for Vasectomy (includes reversals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td><strong>Benefit Highlights</strong></td>
<td><strong>In-Network</strong></td>
<td><strong>Out-Of-Network</strong></td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------</td>
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</tr>
<tr>
<td><strong>Infertility Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage will be provided for the following services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Testing and treatment services performed in connection with an underlying medical condition.</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>- Testing performed specifically to determine the cause of infertility.</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>- Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>- Artificial Insemination, In-vitro, GIFT, ZIFT, etc.</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
</tbody>
</table>

| Physician’s Office Visit (Lab and Radiology Tests, Counseling) | 80% | 80% |
| Primary Care Physician | Plan deductible, then 80% | Plan deductible, then 80% |
| Specialty Care Physician | Plan deductible, then 80% | Plan deductible, then 80% |
| Inpatient Facility | Plan deductible, then 80% | Plan deductible, then 80% |
| Outpatient Facility | Plan deductible, then 80% | Plan deductible, then 80% |
| Inpatient Professional Services | Plan deductible, then 80% | Plan deductible, then 80% |
| Outpatient Professional Services | Plan deductible, then 80% | Plan deductible, then 80% |
| Lifetime Maximum: $15,000 per member | Plan deductible, then 80% | Plan deductible, then 80% |
| Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility). | Plan deductible, then 80% | Plan deductible, then 80% |

| Organ Transplants | 80% | 80% |
| Includes all medically appropriate, non-experimental transplants | 80% | 80% |
| Primary Care Physician’s Office Visit | Plan deductible, then 80% up to transplant maximum | Plan deductible, then 80% up to transplant maximum |
| Specialty Care Physician’s Office Visit | Plan deductible, then 80% up to transplant maximum | Plan deductible, then 80% up to transplant maximum |
| Inpatient Facility | 100% at Lifesource center, otherwise plan deductible, then 80% | Plan deductible, then 80% up to transplant maximum |
| Inpatient Professional Services | 100% at Lifesource center, otherwise, plan deductible, then 80% | Plan deductible, then 80% up to transplant maximum |
| Travel Maximum: $10,000 per transplant | 100% (only available when using Lifesource facility) | In-Network coverage only |

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<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Feeding Equipment and Supplies</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Note: Includes the rental of one breast pump</td>
<td></td>
<td></td>
</tr>
<tr>
<td>per birth as ordered or prescribed by a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>physician. Includes related supplies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>External Prosthetic Appliances</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 visits per person however, the 3 visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>limit will not apply to treatment of mental</td>
<td></td>
<td></td>
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<tr>
<td>health and substance use disorder conditions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Inpatient Professional Services</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Outpatient Professional Services</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Dental Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to charges made for a continuous</td>
<td></td>
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<td>course of dental treatment started within</td>
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<td>six months of an injury to sound, natural</td>
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<td>teeth.</td>
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<tr>
<td>Primary Care Physician’s Office Visit</td>
<td>80%</td>
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<tr>
<td>Specialty Care Physician’s Office Visit</td>
<td>80%</td>
<td>80%</td>
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<tr>
<td>Inpatient Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
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<tr>
<td>Outpatient Facility</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
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<tr>
<td>Inpatient Professional Services</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
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<tr>
<td>Outpatient Professional Services</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
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<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
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<tr>
<td>Routine Foot Disorders</td>
<td>Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.</td>
<td>Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.</td>
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<tr>
<td>Acupuncture</td>
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<tr>
<td>Calendar Year Maximum:</td>
<td>80%</td>
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<tr>
<td>Unlimited</td>
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<tr>
<td>Hearing Aids</td>
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<tr>
<td>Lifetime Maximum:</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
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<tr>
<td>$2,500</td>
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</table>

**Treatment Resulting From Life Threatening Emergencies**

Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.

**Mental Health**

**Inpatient**
- Includes Acute Inpatient and Residential Treatment
- Calendar Year Maximum: Unlimited

**Outpatient**
- Outpatient - Office Visits
  - Includes individual, family and group psychotherapy; medication management, Behavioral Telehealth consultation, etc.
  - Calendar Year Maximum: Unlimited
- Outpatient - All Other Services
  - Includes Partial Hospitalization, Intensive Outpatient Services, Behavioral Telehealth consultation, etc.
  - Calendar Year Maximum: Unlimited
- 80% 80%
<table>
<thead>
<tr>
<th>Benefit Highlights</th>
<th>In-Network</th>
<th>Out-Of-Network</th>
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</thead>
<tbody>
<tr>
<td>Substance Use Disorder</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
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<tr>
<td><strong>Inpatient</strong></td>
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<tr>
<td>Includes Acute Inpatient</td>
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<tr>
<td>Detoxification, Acute Inpatient</td>
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<tr>
<td>Rehabilitation and Residential</td>
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<td>Treatment</td>
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<tr>
<td>Calendar Year Maximum: Unlimited</td>
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<tr>
<td><strong>Outpatient</strong></td>
<td>80%</td>
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<tr>
<td>Outpatient - Office Visits</td>
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<tr>
<td>Includes individual, family and group psychotherapy; medication management, Behavioral Telehealth consultation, etc.</td>
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<td>Calendar Year Maximum: Unlimited</td>
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<tr>
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<td>80%</td>
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<tr>
<td>Includes Partial Hospitalization, Intensive Outpatient Services, Behavioral Telehealth consultation, etc.</td>
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<td>Calendar Year Maximum: Unlimited</td>
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Preferred Provider Medical Benefits

Certification Requirements - Out-of-Network
For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient, except for 48/96 hour maternity stays;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Use Disorder;
- for Mental Health or Substance Use Disorder Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Certification Requirements – Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should only be requested for nonemergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Diagnostic Testing and Outpatient Procedures
Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Hysterectomy.

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- outpatient facility services;
- Partial Hospitalization;
- intensive outpatient programs;
- advanced radiological imaging;
- non-emergency ambulance;
• certain Medical Pharmaceuticals; or
• transplant services.

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. Any applicable Copayments, Deductibles or limits are shown in The Schedule.

Covered Expenses

• charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
• charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
• charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
• charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
• charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
• charges made for Emergency Services and Urgent Care.
• charges made by a Physician or a Psychologist for professional services.
• charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
• charges made for anesthesics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
• charges made for an annual prostate-specific antigen test (PSA).
• charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
• charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
• charges made for the following preventive care services (detailed information is available at www.healthcare.gov.):
  (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
  (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
  (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
  (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
• charges made for surgical or nonsurgical treatment of Temporomandibular Joint Dysfunction.
• charges made for acupuncture.
• charges made for hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
• charges for the delivery of medical and health-related consultations via secure telecommunications technologies, including telephones and internet, when delivered through a contracted medical telehealth provider.

Covered Expenses – Mental Health and Substance Use Disorder

• behavioral consultations and services via secure telecommunications technologies that shall include video capability, including telephones and internet, when delivered through a behavioral provider.
Clinical Trials
This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

(b) either

- the referring health care professional is a participating health care provider and has concluded that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term “life-threatening disease or condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

The study or investigation must:
- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If your plan includes In-Network providers, Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual’s state of residence.

Genetic Testing
Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing.

Nutritional Evaluation
Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Internal Prosthetic/Medical Appliances
Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.
Orthognathic Surgery

- orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
  - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
  - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;
    - physical, occupational and speech therapy;
    - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent’s family or who normally resides in your house or your Dependent’s house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
Mental Health and Substance Use Disorder Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Use Disorder.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Partial Hospitalization or Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

Mental Health Partial Hospitalization Services are rendered no less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program in accordance with the laws of the appropriate, legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Mental Health outpatient benefits include coverage of Applied Behavioral Analysis related to the treatment of autism spectrum disorders (including Autistic Disorder, Asperger's disorder, Pervasive Developmental Disorder not otherwise specified, Rett's Disorder and Childhood Disintegrative Disorder).

Inpatient Substance Use Disorder Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Residential Treatment services.

Substance Use Disorder Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Use Disorder conditions.

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.
A person is considered confined in a Substance Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

**Outpatient Substance Use Disorder Rehabilitation Services**

Services provided for the diagnosis and treatment of Substance Use Disorder or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program.

Substance Use Disorder Partial Hospitalization Services are rendered no less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

**Substance Use Disorder Detoxification Services**

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

**Exclusions**

The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

**Durable Medical Equipment**

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person’s misuse are the person’s responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheelchairs, and dialysis machines.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items**: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturesystem mattresses.
- **Bath Related Items**: bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices**: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- **Fixtures to Real Property**: ceiling lifts and wheelchair ramps.
- **Car/Van Modifications**.
- **Air Quality Items**: room humidifiers, vaporizers, air purifiers and electrostatic machines.
Blood/Injection Related Items: blood pressure cuffs, centrifuges, nova pens and needleless injectors.

Other Equipment: heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

Custom foot orthoses – custom foot orthoses are only covered as follows:

- for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
- when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
- when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
- for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagioccephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - no more than once every 24 months for persons 19 years of age and older;
  - no more than once every 12 months for persons 18 years of age and under; and
  - replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:
- external and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

Infertility Services
- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and the services of an embryologist. Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are specifically excluded infertility services:
- reversal of male and female voluntary sterilization (see Women’s and Men’s Family Planning Services in the Schedule for coverage of these procedures);
- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges and services;
- cryopreservation of donor sperm and eggs; and

- any experimental, investigational or unproven infertility procedures or therapies.

Short-Term Rehabilitative Therapy and Chiropractic Care Services
- charges made for Short-term Rehabilitative Therapy that is part of a rehabilitative program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Also included are services that are provided by a chiropractic Physician when provided in an outpatient setting. Services of a chiropractic Physician include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

The following limitation applies to Short-term Rehabilitative Therapy and Chiropractic Care Services:
- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Short-term Rehabilitative Therapy and Chiropractic Care services that are not covered include but are not limited to:
- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrences or to maintain the patient’s current status;

The following are specifically excluded from Chiropractic Care Services:
- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- vitamin therapy.
If multiple outpatient services are provided on the same day they constitute one day.

Breast Reconstruction and Breast Prostheses
- charges made for reconstructive surgery following a mastectomy; benefits include: surgical services for reconstruction of the breast on which surgery was performed; surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; postoperative breast prostheses; and mastectomy bra and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery
- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

Transplant Services
- charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient’s medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

All Transplant services, other than cornea, are covered at 100% when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with Cigna for those Transplant services, other than Cigna LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are covered at the Out-of-Network level.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation (refer to Transplant Travel Services), hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services
Charges made for non-taxable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation and lodging are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); and lodging while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age. The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills;
alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available when the covered person is a donor.

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that are administered in an Inpatient setting, Outpatient setting, Physician’s office, or in a covered person’s home.

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product’s FDA labeling.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical and/or Prescription Drug Product first.

The Cigna Business Decision Team determines whether utilization management requirements or other coverage conditions should apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee’s evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical’s cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. When considering a Medical Pharmaceutical for a coverage status, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.
### Prescription Drug Benefits

#### The Schedule

**For You and Your Dependents**

This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drug Products. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

As applicable, your Deductible or Coinsurance payment will be based on the Prescription Drug Charge when the Pharmacy is a Network Pharmacy.

**Copayments (Copay)**

Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drug Products.

**Out-of-Pocket Expenses**

Out-of-Pocket Expenses are Covered Expenses incurred at a Pharmacy for Prescription Drug Products for which no payment is provided because of the Coinsurance factor and any Copayments or Deductibles. When the Out-of-Pocket maximum shown in The Schedule is reached, benefits are payable at 100%.

<table>
<thead>
<tr>
<th>Benefit Highlights</th>
<th>Network Pharmacy</th>
<th>Non-Network Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$600 per person</td>
<td>$600 per person</td>
</tr>
<tr>
<td>Family</td>
<td>$1,800 per family</td>
<td>$1,800 per family</td>
</tr>
</tbody>
</table>

**Maintenance Drug Products**

Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Designated Pharmacy or home delivery Pharmacy.

Certain Preventive Care Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required.

**Prescription Drug Products at Retail Pharmacies**

The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy

The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy

**Tier 1**

Generic Drugs on the Prescription Drug List

No charge after $10 copay

In-network coverage only
<table>
<thead>
<tr>
<th>Benefit Highlights</th>
<th>Network Pharmacy</th>
<th>Non-Network Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brand Drugs designated as preferred on the Prescription Drug List</td>
<td>No charge after $25 copay</td>
<td>In-network coverage only</td>
</tr>
<tr>
<td>Tier 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brand Drugs designated as non-preferred on the Prescription Drug List</td>
<td>No charge after $40 copay</td>
<td>In-network coverage only</td>
</tr>
<tr>
<td>Prescription Drug Products at Retail Designated Pharmacies</td>
<td>The amount you pay for up to a consecutive 90-day supply at a Designated Pharmacy</td>
<td>The amount you pay for up to a consecutive 90-day supply at a non-Designated Pharmacy</td>
</tr>
</tbody>
</table>

Note: In this context, a retail Designated Pharmacy is a retail Network Pharmacy that has contracted with Cigna for dispensing of covered Prescription Drug Products, including Maintenance Drug Products, in 90-day supplies.

| Tier 1                                                  |                  |                      |
| Generic Drugs on the Prescription Drug List             | No charge after $20 copay | In-network coverage only |
| Tier 2                                                  |                  |                      |
| Brand Drugs designated as preferred on the Prescription Drug List | No charge after $50 copay | In-network coverage only |
| Tier 3                                                  |                  |                      |
| Brand Drugs designated as non-preferred on the Prescription Drug List | No charge after $80 copay | In-network coverage only |

Note: Infertility medications have a $4,000 Lifetime maximum
All contraceptives are covered at No charge

<p>| Prescription Drug Products at Home Delivery Pharmacies |                  |                      |
| The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy |                      | The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy |
| Tier 1                                                  |                  |                      |
| Generic Drugs on the Prescription Drug List             | No charge after $20 copay | In-network coverage only |
| Tier 2                                                  |                  |                      |
| Brand Drugs designated as preferred on the Prescription Drug List | No charge after $50 copay | In-network coverage only |</p>
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>NETWORK PHARMACY</th>
<th>NON-NETWORK PHARMACY</th>
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</thead>
<tbody>
<tr>
<td>Tier 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brand Drugs designated as non-preferred on the Prescription Drug List</td>
<td>No charge after $80 copay</td>
<td>In-network coverage only</td>
</tr>
</tbody>
</table>

**Note:** Infertility medications have a $4,000 lifetime maximum. All contraceptives are covered at no charge.
Prescription Drug Benefits
For You and Your Dependents

Covered Expenses
Your plan provides benefits for Prescription Drug Products dispensed by a Pharmacy. Details regarding your plan’s Covered Expenses, Limitations and Exclusions are provided below and are shown in The Schedule.

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, Cigna will provide coverage for those expenses as shown in The Schedule. Your benefits may vary depending on which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

Coverage under your plan’s Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed Dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered by Cigna as if filled by a Network Pharmacy. Your payment will be based on the Usual and Customary Charge submitted by the non-Network Pharmacy.

Prescription Drug List Management
The Prescription Drug List (or formulary) offered under your Employer’s plan is managed by the Cigna Business Decision Team. Your plan’s Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. The Business Decision Team makes the final assignment of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and decides whether utilization management requirements or other coverage conditions should apply to a Prescription Drug Product by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee’s evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product’s acquisition cost including, but not limited to,
Limitations

In the event you or your Dependent insist on a more expensive Brand Drug where a Generic Drug is available, you will be financially responsible for the amount by which the cost of the Brand Drug exceeds the cost of the Generic Drug, plus any required Generic Drug Copayment and/or Coinsurance. In this case, the amount by which the cost of the Brand Drug exceeds the cost of the Generic Drug will not apply to your Deductible, if any, or Out of Pocket Maximum. However, in the event your Physician determines that the Generic Drug is not an acceptable alternative for you (and indicates Dispensed as Written on the Prescription Order or Refill), you will only be responsible for payment of the appropriate Brand Drug Coinsurance and/or Copayment after satisfying your Deductible, if any.

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization will depend on the diagnosis, the Prescription Drug Product. The authorization will at all times be subject to the plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

If the prior authorization request is denied, your Physician and you will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the plan by submitting a written request stating why the Prescription Drug Product should be covered.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that has been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria is subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we
may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you may not receive coverage for the Prescription Drug Product or be subject to the non-Network Pharmacy Benefit, if any, for that Prescription Drug Product. Refer to your Schedule of Benefits for further information.

New Prescription Drug Products

The Business Decision Team may or may not place a New Prescription Drug Product on the Prescription Drug List tier upon its market entry. The Business Decision Team will use reasonable efforts to make a tier placement decision for a New Prescription Drug Product within six months of its market availability. The Business Decision Team’s tier placement decision shall be based on consideration of, without limitation, the P&T Committee’s clinical review of the New Prescription Drug Product and economic factors. If a New Prescription Drug Product not listed on the Prescription Drug List is approved by Cigna or its Review Organization as Medically Necessary in the interim, the New Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

After satisfying the plan Deductible, if any, your responsibility for a covered Prescription Drug Product will always be the lowest of:

- the Copayment or Coinsurance for the Prescription Drug Product; or
- the Prescription Drug Charge for the Prescription Drug Product; or
- the Pharmacy’s Usual and Customary (U&C) charge for the Prescription Drug Product.

When a treatment regimen contains more than one type of Prescription Drug Products that are packaged together for your or your Dependent's convenience, any applicable Copayment or Coinsurance may apply to each Prescription Drug Product. Any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded and Cigna or its Review Organization approves as Medically Necessary shall be covered at the applicable coverage tier as set forth in The Schedule.

The amount or your Dependent pays for any excluded Prescription Drug Product or other product or service will not be included in calculating any applicable plan Out-of-Pocket Maximum. You are responsible for paying 100% of the cost (the amount the Pharmacy charges you) for any excluded Prescription Drug Product or other product, and any negotiated Prescription Drug Charge will not be available to you.

Exclusions

Coverage exclusions listed under the “Exclusions, Expenses Not Covered and General Limitations” section also apply to benefits for Prescription Drug Products. In addition, the exclusions listed below apply to benefits for Prescription Drug Products. When an exclusion or limitation applies to only certain Prescription Drug Products, you can access the Internet through the website shown on your ID card or call member services at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

- coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.
- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- Prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- medications used for cosmetic purposes, including, without limitation, medications used to reduce wrinkles.
medications used to promote hair growth, or medications used to control perspiration and fade cream products.

- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

- Medical Pharmaceuticals covered solely under the plan’s medical benefits.

- any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).

- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.

- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.

- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.

- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.

- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.

- medications that are experimental investigational or unproven as described under the “General Exclusion and Limitations” section of your plan’s certificate.

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Reimbursement/Filing a Claim

Retail Pharmacy

When you or your Dependents purchase your Prescription Drug Products through a retail Network Pharmacy, you pay any applicable Copayment, Coinsurance or Deductible shown in The Schedule at the time of purchase. You do not need to file a claim form unless you purchase a Prescription Drug Product at a non-Network Pharmacy.

Home Delivery Pharmacy

To purchase Prescription Drug Products from a home delivery Network Pharmacy, see your home delivery drug introductory kit for details, or contact member services for assistance.

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

- care for health conditions that are required by state or local law to be treated in a public facility.

- care required by state or federal law to be supplied by a public school system or school district.

- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.

- treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.

- 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 example, if Cigna determines that a provider or pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on The Schedule) without Cigna’s express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other.
benefits level not otherwise applicable to the services received.

- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.

- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

- for or in connection with experimental, investigational or unproven services.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, Substance Use Disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;

- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section(s) of this plan; or

- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” section(s) of this plan.

In determining whether drug or Biologic therapies are experimental, investigational and unproven, the utilization review Physician may review, without limitation, U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature.

- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance.

- The following services are excluded from coverage regardless of clinical indications: Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolffing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

- for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.

- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.

- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.

- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.

- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism (except as may otherwise be covered under the plan) or intellectual disabilities.

- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the
“Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.

- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- all noninjectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs and weight loss programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologics that are medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a non-Participating Provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, email, and internet consultations, and telemedicine.
- charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.

**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 you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your or your Dependent’s family.
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 medical 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.
- Governmental benefits as permitted by law, excepting Medicaid, Medicare 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 you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a 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, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

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.

**Effect on the Benefits of This Plan**

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

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 we 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 we request, you must execute and deliver to us such instruments and documents as we 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 us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.
Medicare Eligibles

The Medical Expense Insurance for:

(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;

will be modified, where permitted by the rules established by the Social Security Act of 1965 as amended, as follows:

• For a person age 65 and over, the amount payable under this plan for expenses incurred for which benefits are payable under this plan and Medicare will be reduced by the amount payable for those expenses under Medicare.

• For a person who is under age 65, the amount payable under this plan will be reduced so that the total amount payable by Cigna and Medicare will be no more than 100% of the expenses incurred.

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.

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan when Medicare coverage is due to age. Therefore, when Medicare coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and Cigna is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer rules explained above will apply.

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

• Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant," for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.

• Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

• Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.

• Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the
subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan
By accepting benefits under this plan, a Participant:

• grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;

• agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;

• agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

• No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan’s right to recover shall apply to decedents’, minors’, and incompetent or disabled persons’ settlements or recoveries.

• No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.

• The plan’s right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called “Made-Whole Doctrine”, “Rimes Doctrine”, or any other such doctrine purporting to defeat the plan’s recovery rights by allocating the proceeds exclusively to non-medical expense damages.

• No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan’s rights hereunder, specifically; no court costs, attorneys’ fees or other representatives’ fees may be deducted from the plan’s recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called “Fund Doctrine”, “Common Fund Doctrine”, or “Attorney’s Fund Doctrine”.

• The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.

• The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan’s subrogation or recovery rights are neither affected nor diminished by equitable defenses.

• In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney’s fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

• Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

• Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

Payment of Benefits
To Whom Payable
Medical Benefits are 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 from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, 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 our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our 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. In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

**Calculation of Covered Expenses**

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

Any continuation of insurance must be based on a plan which precludes individual selection.

**Temporary Layoff or Leave of Absence**

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date as determined by your Employer.

**Injury or Sickness**

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer cancels your insurance.

**Retirement**

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer cancels the insurance.

**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 canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

**Recessions**

Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.
Medical Benefits Extension During Hospital Confinement

If the Medical Benefits under this plan cease for you or your Dependent, and you or your Dependent is Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group plan;
- the date you or your Dependent is no longer Hospital Confined; or
- 3 months from the date your Medical Benefits cease.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when your Medical Benefits cease or your Dependent's Medical Benefits cease.

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

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

Notice Regarding Pharmacy Directories and Pharmacy Networks

A list of network pharmacies is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of pharmacies affiliated or contracted with Cigna or an organization contracting on its behalf.

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business;
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Biologic

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsenamine or derivative of arsenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).
Biosimilar
A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

Brand Drug
A Prescription Drug Product that Cigna identifies as a Brand Drug product across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the plan.

Business Decision Team
A committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to make decisions regarding coverage treatment of Prescription Drug Products or Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to Prescription Drug Products or Medical Pharmaceuticals.

Charges
The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount.

Cigna Home Delivery Pharmacy
A home delivery Network Pharmacy owned and operated by licensed Pharmacy affiliates of Cigna Health and Life Insurance Company.

Custodial Services
Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person’s current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self-administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Dependent
Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is:
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more
frequently than once a year, Cigna may require proof of
the continuation of such condition and dependence.
The term child means a child born to you or a child legally
adopted by you. It also includes a stepchild, a foster child, or a
child for whom you are the legal guardian. If your Domestic
Partner has a child, that child will also be included as a
Dependent.
Benefits for a Dependent child will continue until the last day
of the calendar month in which the limiting age is reached.
Anyone who is eligible as an Employee will not be considered
as a Dependent spouse. A child under age 26 may be covered
as either an Employee or as a Dependent child. You cannot be
covered as an Employee while also covered as a Dependent of
an Employee.
No one may be considered as a Dependent of more than one
Employee.

Designated Pharmacy
A Network Pharmacy that has entered into an agreement with
Cigna, or with an entity contracting on Cigna’s behalf, to
provide Prescription Drug Products or services, including,
without limitation, specific Prescription Drug Products, to plan
enrollees on a preferred or exclusive basis. For example, a
Designated Pharmacy may provide enrollees certain Specialty
Prescription Drug Products that have limited distribution
availability, provide enrollees with an extended days’ supply
of Prescription Drug Products or provide enrollees with
Prescription Drug Products on a preferred cost share basis.
The fact that a Pharmacy is a Network Pharmacy does not
mean that it is a Designated Pharmacy.

Domestic Partner
Only Domestic Partners as defined in Section 2.2, are eligible
for coverage under this Plan.

Emergency Medical Condition
Emergency medical condition means a medical condition
which manifests itself by acute symptoms of sufficient
severity (including severe pain) such that a prudent layperson,
who possesses an average knowledge of health and medicine,
Essential Health Benefits

Essential health benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

HC-DFS411

Expense Incurred
An expense is incurred when the service or the supply for which it is incurred is provided.

HC-DFS40

Free-Standing Surgical Facility
The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

HC-DFS51

Generic Drug
A Prescription Drug Product that Cigna identifies as a Generic Drug product at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics (including Biosimilars) as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the plan. A Biosimilar may be classified as a Generic Drug for the purposes of benefits under the plan even if it is identified as a “brand name” drug by the manufacturer, Pharmacy or your Physician.

HC-DFS846

Hospice Care Program
The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

HC-DFS52

Hospice Care Services
The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

HC-DFS52

Hospice Facility
The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

HC-DFS52

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Hospital

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance Use Disorder or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

Injury

The term Injury means an accidental bodily injury.

Maintenance Drug Product

A Prescription Drug Product that is prescribed for use over an extended period of time for the treatment of chronic or long-term conditions such as asthma, hypertension, diabetes and heart disease, and is identified principally based on consideration of available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source and clinical factors. For the purposes of benefits, the list of your plan’s Maintenance Drug Products does not include compounded medications, Specialty Prescription Drug Products or Prescription Drug Products, such as certain narcotics, that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or Refill under applicable federal or state law. You may determine whether a drug is a Maintenance Medication by calling member services at the telephone number on your ID card.

Maximum Reimbursable Charge - Medical

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider’s normal charge for a similar service or supply; or
- a policyholder-selected percentage of a schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

The percentage used to determine the Maximum Reimbursable Charge is listed in The Schedule. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider’s normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.
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.

Medical Pharmaceutical
An FDA-approved prescription pharmaceutical product, including a Specialty Prescription Drug Product, typically required to be administered in connection with a covered service by a Physician or other health care provider within the scope of the provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling. This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

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

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

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

Necessary Services and Supplies
The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Network Pharmacy
A retail or home delivery Pharmacy that has:

- entered into an agreement with Cigna or an entity contracting on Cigna's behalf to provide Prescription Drug Products to plan enrollees.
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- been designated as a Network Pharmacy for the purposes of coverage under your Employer's plan.

New Prescription Drug Product
A Prescription Drug Product, or new use or dosage form of a previously FDA-approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug
Product or newly-approved use or dosage form becomes available on the market following approval by the U.S. Food and Drug Administration (FDA) and ending on the date Cigna's Business Decision Team makes a Prescription Drug List coverage status decision.

**Nurse**
The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.,” “L.P.N.” or "L.V.N..”

**Other Health Care Facility/Other Health Professional**
The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

**Participating Provider**
The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

**Patient Protection and Affordable Care Act of 2010 ("PPACA")**
Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

**Pharmacy**
A duly licensed Pharmacy that dispenses Prescription Drug Products in a retail setting or via home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drug Products through mail order.

**Pharmacy & Therapeutics (P&T) Committee**
A committee comprised of both voting and non-voting Cigna-employed clinicians, Medical Directors and Pharmacy Directors and non-employees such as Participating Providers that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals or Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

**Physician**
The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.
Prescription Drug Charge

The amount the plan pays to Cigna, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy. Cigna may pay a Network Pharmacy a different amount for a Prescription Drug Product than the plan pays to Cigna.

HC-DFSS55 10-16

Prescription Drug List

A list that categorizes drugs, Biologics (including Biosimilars) or other products covered under the plan’s Prescription Drug benefits that have been approved by the U.S. Food and Drug Administration (FDA) into coverage tiers. This list is developed by Cigna’s Business Decision Team based on clinical factors communicated by the P&T Committee, and adopted by your Employer as part of the plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.

HC-DFSS54 10-16

Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the plan, this definition also includes:

- The following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Insulocan, insulin pumps, needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips;
- Needles and syringes for self-administered medications or Biologics covered under the plan’s Prescription Drug benefit; and
- Inhaler assistance devices and accessories, peak flow meters.

This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

HC-DFSS55 10-16

Prescription Order or Refill

The lawful directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

HC-DFSS56 10-16

Preventive Care Medications

The Prescription Drug Products or other medications (including over-the-counter medications) designated as payable by the plan at 100% of the cost (without application of any Deductible, Copayment or Coinsurance) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

A written prescription is required to process a claim for a Preventive Care Medication. You may determine whether a drug is a Preventive Care Medication through the Internet website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-DFSS57 1G-16

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and

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performing a service for which benefits are provided under this plan when performed by a Psychologist.

Retiree
The term Retiree means any eligible retiree, as defined in Section 2.1.

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

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.

Skilled Nursing Facility
The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis; but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

Specialist
The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

Specialty Prescription Drug Product
A Prescription Drug Product or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Prescription Drug Product or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug Product or Medical Pharmaceutical has a high acquisition cost; and, whether the Prescription Drug Product or Medical Pharmaceutical is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug Product or Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, or by tier assignment or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

Stabilize
Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.
Terminal Illness
A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Pharmacy by third parties. The Usual and Customary (U&C) Charge includes a dispensing fee and any applicable sales tax.

Therapeutic Alternative
A Prescription Drug Product or Medical Pharmaceutical that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

Therapeutic Equivalent
A Prescription Drug Product or Medical Pharmaceutical that is a pharmaceutical equivalent to another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

Urgent Care
Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

Usual and Customary (U&C) Charge
The usual fee that a Pharmacy charges individuals for a Prescription Drug Product (and any services related to the dispensing thereof) without reference to reimbursement to the
Middlebury

CIGNA DENTAL PREFERRED PROVIDER INSURANCE

EFFECTIVE DATE: January 1, 2017

AS02
3339660

This document printed in February, 2017 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
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Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY MIDDLEBURY WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."
Explanation of Terms
You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

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

Cigna, in its role as benefits administrator, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:
- Provides free aids and services to people with disabilities to communicate effectively with Cigna, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Customer Service/Member Services at the toll-free phone number shown on your ID card, and ask an associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address: Cigna, Nondiscrimination Complaint Coordinator, P.O. Box 188016, Chattanooga, TN 37422.

If you need assistance filing a written grievance, please call the toll-free phone shown on your ID card or send an email to ACAGrievance@cigna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; or by phone at 1-800-368-1019, 888-537-7697 (TDD).


Proficiency of Language Assistance Services

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

Spanish

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

Chinese

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

Vietnamese

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

Korean

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

Tagalog

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

Russian

ВНИМАНИЕ: вы можете получить бесплатные услуги перевода. Если вы уже сотрудничаете с Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1-800-244-6224 (TTY: 711).

Arabic

Cigna برامج اللغة خدمات الترجمة المجانية متاحة لكم، لعملاء الأجانب Cigna الاتصال بالرقم المدون على ظهر بطاقة الشخصية، أو أتصل ب 1-800-244-6224 (TTY: T1-711).

French Creole

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

mvCigna.com
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 calling Member Services 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 YOUR CIGNA CLAIM OFFICE.**

- YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- **BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.**

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) 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 one year, 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 material false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Eligibility - Effective Date

**Employee Insurance**

This plan is offered to you as an Employee.
Eligibility for Employee Insurance
You will become eligible for insurance on the day you complete the waiting period once you meet the definition in section 2.1.

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Eligibility for Dependent Insurance
You will become eligible for Dependent insurance on the later of:
- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period
Initial Employee Group: None.
New Employee Group: First of the month coincident with or next following your employment, or your classification as an Eligible Employee.

Classes of Eligible Employees
Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance
Employees can be effective retroactively to their date of eligibility assuming they enroll within 30 days and were actively employed on their eligibility date.

Late Entrant - Employee
You are a Late Entrant if:
- you don’t enroll during your first open enrollment period.

Dependent Insurance
For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance
Employees can be effective retroactively to their date of eligibility assuming they enroll within 30 days and were actively employed on their eligibility date.
Cigna Dental Preferred Provider Insurance

The Schedule

For You and Your Dependents

The Dental Benefits Plan offered by your Employer includes Participating and non-Participating Providers. If you select a Participating Provider, your cost may be lower than if you select a non-Participating Provider.

Emergency Services

The Benefit Percentage payable for Emergency Services charges made by a non-Participating Provider is the same Benefit Percentage as for Participating Provider Charges. Dental Emergency Services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

Deductibles

Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that year.

Participating Provider Payment

Participating Provider services are paid based on the Contracted Fee that is agreed to by the provider and Cigna. Based on the provider’s Contracted Fee, a higher level of plan payment may be made to a Participating Provider resulting in a lower payment responsibility for you. To determine how your Participating Provider compares refer to your provider directory.

Provider information may change annually; refer to your provider directory prior to receiving a service. You have access to a list of all providers who participate in the network by visiting www.mycigna.com.

Non-Participating Provider Payment

Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 90th percentile of all provider charges in the geographic area.

Simultaneous Accumulation of Amounts

Benefits paid for Participating and non-Participating Provider services will be applied toward both the Participating and non-Participating Provider maximum shown in the Schedule.

Expenses incurred for either Participating or non-Participating Provider charges will be used to satisfy both the Participating and non-Participating Provider Deductibles shown in the Schedule.

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<td>Calendar Year Deductible</td>
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<td>Preventive Care</td>
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<tr>
<td>Class II</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
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<tr>
<td>Basic Restorative</td>
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<td>Class III</td>
<td>80% after plan deductible</td>
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<td>Major Restorative</td>
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<td>Class IV</td>
<td>80% after plan deductible</td>
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<td>Orthodontia</td>
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<td>Class IX</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
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<td>Implants</td>
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Missing Teeth Limitation
There is no payment for replacement of teeth that are missing when a person first becomes insured. This payment limitation no longer applies after 12 months of continuous coverage. This limit will not apply to any person who is a member of the Initial Employee group.

Covered Dental Expense
Covered Dental Expense means that portion of a Dentist’s charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the Necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule has been met;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the “Benefits Extension” section.

Alternate Benefit Provision
If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment.

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits
Predetermination of Benefits is a voluntary review of a Dentist’s proposed treatment plan and expected charges. It is not preauthorization of service and is not required.

The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by Cigna’s dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, Cigna will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $200. Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Covered Services
The following section lists covered dental services. Cigna may agree to cover expenses for a service not listed. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

Dental PPO – Participating and Non-Participating Providers
Plan payment for a covered service delivered by a Participating Provider is the Contracted Fee for that procedure, times the benefit percentage that applies to the class of service, as specified in The Schedule. The covered person is responsible for the balance of the Contracted Fee.

Plan payment for a covered service delivered by a non-Participating Provider is the Maximum Reimbursable Charge for that procedure, times the benefit percentage that applies to the class of service, as specified in The Schedule. The covered person is responsible for the balance of the non-Participating Provider’s actual charge.

Class I Services – Diagnostic and Preventive
Clinical oral examination – Only 2 per person per calendar year.
Bitewing x-rays – Only 2 charges per person per calendar year.
Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) – Only 2 per person per calendar year.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Only 1 per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth for a person up to age 19 - Only 1 treatment per tooth in any 3 calendar years.

Class II Services – Basic Restorations, Periodontics, Endodontics, Oral Surgery, Prosthodontic Maintenance
Amalgam Filling (excluding ABP)
Composite (covered on all teeth)/Resin Filling (excluding ABP)
Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.
Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.

Periodontal Scaling and Root Planing – Entire Mouth
Adjustments – Complete Denture
Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recement Bridge
Routine Extractions
Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth
Removal of Impacted Tooth, Soft Tissue
Removal of Impacted Tooth, Partially Bony
Removal of Impacted Tooth, Completely Bony
Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.

General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 36 consecutive months.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

Class III Services - Major Restorations, Dentures and Bridgework

Crows
Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

Porcelain Fused to High Noble Metal
Full Cast, High Noble Metal
Three-Quarters Cast, Metallic

Removable Appliances
Complete (Full) Dentures, Upper or Lower
Partial Dentures
Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)
Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances
Bridge Pontics - Cast High Noble Metal
Bridge Pontics - Porcelain Fused to High Noble Metal
Bridge Pontics - Resin with High Noble Metal
Retainer Crowns - Resin with High Noble Metal
Retainer Crowns - Porcelain Fused to High Noble Metal
Retainer Crowns - Full Cast High Noble Metal
Prosthesis Over Implant – A prosthetic device, supported by
an implant or implant abutment is a Covered Expense.
Replacement of any type of prosthesis with a prosthesis
supported by an implant or implant abutment is only payable
if the existing prosthesis is at least 60 consecutive months old,
is not serviceable and cannot be repaired.

Implant coverage may have a separate deductible amount,
yearly maximum and/or lifetime maximum as shown in The
Schedule.

Class IV Services - Orthodontics
Each month of active treatment is a separate Dental Service.
Covered Expenses include:
Orthodontic work-up including x-rays, diagnostic casts and
treatment plan and the first month of active treatment
including all active treatment and retention appliances.
Continued active treatment after the first month.
Fixed or Removable Appliances - Only one appliance per
person for tooth guidance or to control harmful habits.
Periodic observation of patient dentition to determine when
orthodontic treatment should begin, at intervals established
by the dentist, up to four times per calendar year.
The total amount payable for all expenses incurred for
orthodontics during a person's lifetime will not be more than
the orthodontia maximum shown in the Schedule.
Payments for comprehensive full-banded orthodontic
treatment are made in installments. Benefit payments will be
made every 3 months. The first payment is due when the
appliance is installed. Later payments are due at the end of
each 3-month period. The first installment is 25% of the
charge for the entire course of treatment. The remainder of the
charge is prorated over the estimated duration of treatment.
Payments are only made for services provided while a person
is insured. If insurance coverage ends or treatment ceases,
payment for the last 3-month period will be prorated.

Expenses Not Covered
Covered Expenses will not include, and no payment will be
made for:
• services performed solely for cosmetic reasons;
• replacement of a lost or stolen appliance;
• replacement of a bridge, crown or denture within 5 years
  after the date it was originally installed unless: the
  replacement is made necessary by the placement of an
  original opposing full denture or the necessary extraction of
  natural teeth; or the bridge, crown or denture, while in
  the mouth, has been damaged beyond repair as a result of an
  injury received while a person is insured for these benefits;
• any replacement of a bridge, crown or denture which is or
  can be made useable according to common dental standards;
• procedures, appliances or restorations (except full dentures)
  whose main purpose is to change vertical dimension;
  diagnose or treat conditions or dysfunction of the
  temporomandibular joint; stabilize periodontally involved
  teeth; or restore occlusion;
• porcelain or acrylic veneers of crowns or pontics on, or
  replacing the upper and lower first, second and third molars;
• bite registrations; precision or semiprecision attachments; or
  splinting;
• instruction for plaque control, oral hygiene and diet;
• dental services that do not meet common dental standards;
• services that are deemed to be medical services;
• services and supplies received from a Hospital;
• services for which benefits are not payable according to the
  “General Limitations” section.

Class IX Services - Implants
Covered Dental Expenses include: the surgical placement of
the implant body or framework of any type; any device, index,
or surgical template guide used for implant surgery;
prefabricated or custom implant abutments; or removal of an
existing implant. Implant removal is covered only if the
implant is not serviceable and cannot be repaired.
General Limitations

Dental Benefits

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

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- 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 condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received;
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

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VII

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 medical or dental 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.
- Governmental benefits as permitted by law, excepting Medicaid, Medicare 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 you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

• If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

• If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a 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, but does not include any part of a year during which you are not covered under this policy for any date before this section or any similar provision takes effect.

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.

Effect on the Benefits of This Plan

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

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 we 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
we request, you must execute and deliver to us such
instruments and documents as we 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 us with any
information we request in order to coordinate your benefits
pursuant to this section. This request may occur in connection
with a submitted claim; if so, you will be advised that the
"other coverage" information, (including an Explanation of
Benefits paid under the Primary Plan) is required before the
claim will be processed for payment. If no response is
received within 90 days of the request, the claim will be
denied. If the requested information is subsequently received,
the claim will be processed.

Expenses For Which A Third Party May
Be Responsible
This plan does not cover:

• Expenses incurred by you or your Dependent (hereinafter
  individually and collectively referred to as a "Participant,")
  for which another party may be responsible as a result of
  having caused or contributed to an Injury or Sickness.
• Expenses incurred by a Participant to the extent any
  payment is received for them either directly or indirectly
  from a third party tortfeasor or as a result of a settlement,
  judgment or arbitration award in connection with any
  automobile medical, automobile no-fault, uninsured or
  underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or
  similar type of insurance or coverage.

Right Of Reimbursement
If a Participant incurs a Covered Expense for which, in the
opinion of the plan or its claim administrator, another party
may be responsible or for which the Participant may receive
payment as described above, the plan is granted a right of
reimbursement, to the extent of the benefits provided by the
plan, from the proceeds of any recovery whether by
settlement, judgment, or otherwise.

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

Additional Terms
• No adult Participant hereunder may assign any rights that it
  may have to recover medical expenses from any third party
  or other person or entity to any minor Dependent of said
  adult Participant without the prior express written consent
  of the plan. The plan's right to recover shall apply to
  decedents', minors', and incompetent or disabled persons'
  settlements or recoveries.
• No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.

• The plan’s right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called “Made-Whole Doctrine”, “Rimes Doctrine”, or any other such doctrine purporting to defeat the plan’s recovery rights by allocating the proceeds exclusively to non-medical expense damages.

• No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan’s rights hereunder, specifically; no court costs, attorneys’ fees or other representatives’ fees may be deducted from the plan’s recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called “Fund Doctrine”, “Common Fund Doctrine”, or “Attorney’s Fund Doctrine”.

• The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.

• The plan hereby disavows all equitable defenses in the pursuit of its right of recovery. The plan’s recovery rights are neither affected nor diminished by equitable defenses.

• In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney’s fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

• Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

• Participants must assist the plan in pursuing any recovery rights by providing requested information.

Payment of Benefits

To Whom Payable

Dental Benefits are 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 from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, 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 our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our 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. In addition, your acceptance of benefits under this plan and/or assignment of Dental Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.
Miscellaneous
As a Cigna Dental plan member, you may be eligible for various discounts, benefits, or other consideration for the purpose of promoting your general health and well being. Please visit our website at www.cigna.com for details.

If you are a Cigna Dental plan member you may be eligible for additional dental benefits during certain episodes of care. For example, certain frequency limitations for dental services may be relaxed for pregnant women, diabetics or those with cardiac disease. Please review your plan enrollment materials for details.

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 canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence
If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness
If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, your insurance will not continue past the date your Employer cancels your insurance.

Retirement
If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer cancels your insurance.

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 canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

Dental Benefits Extension
An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.
Federal Requirements
The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

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

Eligibility for Coverage for Adopted Children
Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance, if otherwise eligible as a Dependent, upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child’s adoption.
If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.
The provisions in the “Exception for Newborns” section of this document that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Group Plan Coverage Instead of Medicaid
If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

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

Continuation of Coverage
For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.
For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:
You may continue benefits by paying the required premium to your Employer, until the earliest of the following:
- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.
Your Employer may charge you and your Dependents up to 102% of the total premium.
Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any “Conversion Privilege” shown in your certificate.

Reinstatement of Benefits (applicable to all coverages)
If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.
You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

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

Definitions

Active Service
You will be considered in Active Service:
- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

Coincidence
The term Coincidence means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contracted Fee
The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on an Employee or Dependent, according to the Employee's dental benefit plan.

Dentist
The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a provider operating within the scope of his license when he performs any of the Dental Services described in the policy.

Dependent
Dependents are:
- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild, a foster child, or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

Domestic Partner
Only Domestic Partners as defined in Section 2.2, are eligible for coverage under this Plan

myCigna.com
Employee
The term Employees means any eligible employee, as defined in Section 2.1.

Employer
The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf Cigna is providing claim administration services.

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

Participating Provider
The term Participating Provider means: a dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a contract with Cigna to provide dental services at predetermined fees.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by your Employer.

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.
VISION SERVICE PLAN INSURANCE COMPANY
3333 QUALITY DRIVE
RANCHO CORDOVA, CALIFORNIA 95670

GROUP VISION CARE POLICY

Group Name: PRESIDENT AND FELLOWS OF MIDDLEBURY COLLEGE
Policy Number: 30022396
State of Delivery: VERMONT
Effective Date: JANUARY 1, 2016
Policy Term: TWENTY-FOUR (24) MONTHS
Premium Due Date: FIRST DAY OF MONTH

In consideration of the statements and agreements contained in the Group Application and in consideration of payment by the Group of the premiums as herein provided, VISION SERVICE PLAN INSURANCE COMPANY ("the Company") agrees to insure certain individuals under this Group Vision Care Policy ("Policy") the benefits provided herein, subject to the exceptions, limitations and exclusions hereinafter set forth. This Policy is delivered in and governed by the laws of the state of delivery and is subject to the terms and conditions recited on the subsequent pages hereof, which are a part of this Policy.

Kate Renwick-Espinosa, President
VISION SERVICE PLAN INSURANCE COMPANY
GROUP VISION CARE POLICY
SECTION 1.
DEFINITIONS

Key terms used in this Policy are defined and shall have the meaning set forth as follows, unless the context of a term's usage clearly requires otherwise:

1.01. **ADMINISTRATIVE SERVICES PROGRAM**: A group vision care plan whereby Group pays the Company for the Plan Benefits in addition to a monthly administrative fee.

1.02. **ANISOMETROPIA**: A condition of unequal refractive state for the two eyes, one eye requiring a different lens correction than the other.

1.03. **BENEFIT AUTHORIZATION**: Authorization issued by the Company identifying the individual named as Insured of the Company, and identifying those Policy Benefits to which Insured is entitled.

1.04. **CONFIDENTIAL MATTER**: All confidential or personal information concerning the medical, personal, financial or business affairs of Insured acquired in the course of providing Plan Benefits hereunder.

1.05. **COPAYMENTS**: Those amounts required to be paid by or on behalf of a Insured for Plan Benefits which are not fully covered.

1.06. **ELIGIBLE DEPENDENT**: Any legal dependent of an Enrollee of Group who meets the criteria for eligibility established by Group and approved by the Company in Section VI. of this Policy under which such Enrollee is covered.

1.07. **EMERGENCY CONDITION**: A condition, with sudden onset and acute symptoms, that requires the Insured to obtain immediate medical care, or an unforeseen occurrence calling for immediate, non-medical action.

1.08. **ENROLLEE**: An employee or member of Group who meets the criteria for eligibility specified under Section VI. Eligibility For Coverage.

1.09. **EXPERIMENTAL NATURE**: Procedure or lens that is not used universally or accepted by the vision care profession, as determined by the Company.

1.10. **GROUP**: An employer or other entity who contracts with the Company for coverage under this Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents.

1.11. **GROUP APPLICATION**: The form signed by an authorized representative of the Group to signify the Group's intention to have its Enrollees and their Eligible Dependents become Insured of the Company.
1.12. **GROUP VISION CARE POLICY** (also, "The Policy"): The Policy issued by the Company in favor of a Group, under which its Enrollees or members, and their Eligible Dependents are entitled to become Insureds of the Company and receive Plan Benefits in accordance with the terms of such Policy.

1.13. **INSURED**: An Enrollee or Eligible Dependent who meets Insured’s eligibility criteria and on whose behalf Premiums have been paid to the Company, and who is covered under this Policy.

1.14. **KERATOCONUS**: A development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

1.15. **MEMBER DOCTOR**: An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with the Company to provide vision care services and/or vision care materials on behalf of Insureds of the Company.

1.16. **NON-MEMBER PROVIDER**: Any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with the Company to provide vision care services and/or vision care materials to Insureds of the Company.

1.17. **PLAN ADMINISTRATOR**: The person specifically so designated on the application, or if an administrator is not so designated, the Group. The Plan Administrator shall have authority to control and manage the operation and administration of the Policy on behalf of the Group.

1.18. **PLAN BENEFITS**: The vision care services and vision care materials that Insured is entitled to receive by virtue of coverage under this Policy, as defined in the Schedule of Benefits attached hereto as Exhibit A.

1.19. **PREMIUMS**: The payments made to the Company by Group on behalf of an Insured to entitle him/her to Plan Benefits, as stated in the Schedule of Premiums attached hereto as Exhibit B.

1.20. **RENEWAL DATE**: The date on which the Policy shall renew, or expire if proper notice is given.

1.21. **SCHEDULE OF BENEFITS**: The document, attached hereto as Exhibit A, that lists the vision care services and vision care materials that Insured is entitled to receive by virtue of coverage under this Policy.
SECTION II.
TERM, TERMINATION, AND RENEWAL

2.01. **Plan Term:** This Policy shall become effective on the date first above stated, and shall remain in effect for the Policy Term. At the expiration of the Policy Term, the Policy shall renew on a month-to-month basis unless either party notifies the other in writing, at least sixty (60) days before the end of the Policy Term, that such party is unwilling to renew the Policy. If such notice is given, the Policy shall expire at 12:00 midnight on the last day of the Policy Term unless the parties reach mutual agreement on its renewal.

2.02. **Early Termination Provision:** The premium rate(s) payable by Group under this Agreement is based on an assumption that the Company will receive these amounts over the full Policy Term in order to cover costs associated with greater vision utilization that tends to occur during the first portion of a Policy Term. If this Agreement is terminated by Group before the end of the Policy Term or any subsequent renewal terms, for any reason other than material breach by the Company, Group will remain liable to the Company for the lesser amount of any deficit incurred by the Company or the payments which Group would have paid for the remaining term of this Policy, not to exceed one year. A deficit incurred by the Company will be calculated by subtracting the cost of incurred and outstanding claims, as calculated on an incurred date basis with a claim run-out not to exceed six months from the date of termination, from the net premiums received by the Company from Group. Net premiums shall mean premiums paid by Group minus any applicable retention amounts and/or broker commissions. Group agrees to pay the Company within thirty-one (31) days of notification of the amount due.
SECTION III.
OBLIGATIONS OF THE COMPANY

3.01. **Coverage of Insureds:** The Company will enroll for coverage each eligible Enrollee and his/her Eligible Dependents, if dependent coverage is provided, all of whom shall be referred to upon enrollment as "Insureds." To institute coverage, Group may be required by the Company to complete and sign a Group Application and forward such application to the Company, along with information regarding Enrollees and Eligible Dependents, and all applicable Premiums. (Refer to Section VI. Eligibility For Coverage for further details.)

Following the enrollment of the Insured, the Company will make available to all Insureds a Member Benefit Summary. Such Member Benefit Summary will summarize the terms and conditions set forth in this Policy.

3.02. **Provision of Plan Benefits:** Through its Member Doctors (or through other licensed vision care providers where the Insured chooses to receive Plan Benefits from a Non-Member Provider), the Company shall provide Insureds such Plan Benefits listed in the Schedule of Benefits (Exhibit A hereto), subject to any limitations, exclusions, or Copayments therein stated. When the Insured desires to receive Plan Benefits from a Member Doctor, the Insured shall contact the Company or the Member Doctor. The Company shall provide Benefit Authorization to the Member Doctor or to the eligible Insured for use in receiving Plan Benefits from a Member Doctor. Benefit Authorization shall be issued by the Company in accordance with the latest eligibility information furnished by Group and past service utilization, if any. Any Benefit Authorization so issued by the Company shall constitute a certification to the Member Doctor that payment will be made. The Company shall not be held liable to Group for any Benefit Authorizations so issued in error. Insureds are required to obtain the Benefit Authorization prior to obtaining Plan Benefits in cases where the Insured obtains Plan Benefits from a Member Doctor (see Section 5.03 for further details).

The Company shall pay or deny claims for Plan Benefits provided to Insureds, less any applicable Copayment, within a reasonable time but not more than thirty (30) calendar days after the Company has received a completed claim, unless special circumstances require additional time. In such cases, the Company may obtain an extension of fifteen (15) calendar days of this time limit by providing notice to the claimant of the reasons for the extension.
3.03. **Provision of Information to Insureds:** The Company shall make available to the Insured necessary information describing Plan Benefits and the appropriate method for using them. A copy of this Policy shall be placed with Group and also will be made available at the offices of the Company for any Insureds who wish to inspect or copy it. The Company shall provide to Insureds an updated list of Member Doctors' names, addresses, and telephone numbers.

3.04. **Preservation of Confidentiality:** The Company shall hold in strict confidence all Confidential Matters and exercise its best efforts to prevent any of its employees, Member Doctors, or agents, from disclosing any Confidential Matter, except to the extent that such disclosure is necessary to enable any of the above to perform their obligations under this Policy, including but not limited to, sharing information with medical information bureaus, or as may otherwise be required by law.

3.05. **Emergency Vision Care:** When vision care is necessary for Emergency Conditions, Insureds may obtain Plan Benefits by contacting a Member Doctor or Non-Member Provider. No prior approval from the Company is required for Insured to obtain vision care for Emergency Conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by the Company only under the Acute EyeCare and Supplemental Primary EyeCare Plans. If Group has not purchased one of these plans, Insureds are not covered by the Company for medical services and should contact a physician under Insureds' medical insurance plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Insured should contact the Company's Customer Service Department for assistance. Reimbursement and eligibility are subject to the terms of this Policy.
SECTION IV.
OBLIGATIONS OF THE GROUP

4.01. Identification of Eligible Enrollees: An Enrollee is eligible for coverage under this Policy if he/she satisfies the enrollment criteria specified in Paragraph 6.01(a) and/or as mutually agreed to by the Company and Group. By the effective date of this Policy, Group shall provide the Company with a listing, in a form approved by the Company, of all of its Enrollees who are eligible for coverage under this Policy as of that date and a designation of family status for each such Enrollee, if dependent coverage is provided. Thereafter, Group shall supply to the Company on or before the last day of each month, in a form approved by the Company, a listing of all Enrollees with a designation of family status who will be added to or deleted from the Company's coverage rosters for the succeeding month.

4.02. Payment of Premiums: On or before the first day of each month, Group shall remit to the Company the premiums payable for the succeeding month on behalf of each Enrollee and Eligible Dependents, if any, to be covered under this Policy for such succeeding month. The amount of such Premiums for each Insured shall be as provided in the Schedule of Premiums incorporated in this Policy as Exhibit B. Only Insureds for whom Premiums are actually received by the Company shall be entitled to Plan Benefits hereunder and only for the period for which such payment is received, subject to the grace period provision below. If payment for any Insured is not received by the time specified above, the Company reserves the right to terminate all rights of such Insured, and such rights may be reinstated only in accordance with the requirements of this Policy.

The Company may change the Premiums shown on the attached Schedule of Premiums, (Exhibit B) by giving Group at least sixty (60) days advance written notice. The Company may change the Premiums at any time the Schedule of Benefits or any other terms and conditions of this Policy are changed. No change will be made during the Policy Term unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Policy. No change will be made more often than once during any twelve (12) month period unless there is a change in the Schedule of Benefits or a change in any other terms and conditions of the Policy.

Notwithstanding the above, the Company reserves the right to increase Premiums required hereunder by the amount of any tax or assessment not now in effect which is subsequently levied by any taxing authority, which is attributable to the Premiums the Company receives from Group.
4.03. **Grace Period:** Group shall be allowed a grace period of thirty-one (31) days following the due date for making any payment of Premiums due under this Policy. During said grace period, this Policy shall remain in full force and effect for all Insureds covered hereunder.

If Group fails to make any payment of Premiums due by the end of any grace period, the Company may notify Group that the payment of Premiums has not been made, that coverage is canceled and that the Group is responsible for payment of all Plan Benefits provided to Insureds after the last period for which Premiums were fully paid, including the grace period.

4.04. **Other Information to be Provided:** Group shall furnish to the Company monthly, during the effective period of this Policy, such information as may reasonably be required by the Company for the purposes of this Policy, including listings of new Enrollees, terminations of eligibility and changes in the family status of covered Enrollees. Such information shall be supplied in a form specified by the Company. In addition, Group shall, when requested, make available for inspection by the Company such records as may have bearing on the coverage of Insureds under this Policy.

4.05. **Distribution of Required Documents:** Group agrees to distribute to Enrollees any disclosure forms, plan summaries or other material that may be required to be given to plan subscribers by any regulatory authority. Such materials shall be distributed by Group to Enrollees no later than thirty (30) days after the receipt thereof.

4.06. **Risk-to-ASP Conversion Provision:** Converting to an Administrative Services Program: Due to the cyclical nature of vision care, in the event Group wishes to convert its method of funding from a risk program to an Administrative Services Program, an appropriate level of reserve will need to have been established.

Upon conversion to an Administrative Services Program, for vision care begun on and after the effective date of conversion, all claims will be paid through the Administrative Services Program.
SECTION V.
OBLIGATIONS OF INSUREDS UNDER THE POLICY

5.01. **General:** By this Policy, Group makes coverage available to its Enrollees and their Eligible Dependents, if dependent coverage is provided. However, this Policy may be amended or terminated by agreement between the Company and Group without the consent or concurrence of the Insureds. This Policy, and all Exhibits, attachments and amendments attached hereto constitute the Company’s sole and entire undertaking to Insureds under this Policy.

All Insureds under this Policy shall have the following obligations as a condition of their coverage.

5.02. **Copayments for Services Received:** Where, as indicated on the Schedule of Benefits, Exhibit A hereto, Copayments are required for certain Plan Benefits, these Copayments shall be the personal responsibility of the Insured receiving the care and must be paid to the Member Doctor on the date the services are rendered.

5.03. **Authorization of Services:** The Insured must receive Benefit Authorization before receiving Plan Benefits from a Member Doctor. Such Benefit Authorization is received by contacting a Member Doctor or the Company. Should the Insured receive Plan Benefits from a Member Doctor without such Benefit Authorization, then for the purposes of those Plan Benefits provided to the Insured, the provider will be considered a Non-Member Provider, and the benefits available will be limited to those for a Non-Member Provider, if any.

5.04. **Complaints and Grievances: Time of Action:** Insureds shall report any complaints and/or grievances to the Company at the address given herein. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to the Company verbally or in writing. Insured may submit written comments or supporting documentation concerning his/her complaint or grievance to assist in the Company’s review. The Company will resolve the complaint or grievance within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) days after the Company’s receipt of the complaint or grievance. If the Company determines that resolution cannot be achieved within thirty (30) days, the Company will notify the Insured of the expected resolution date. Upon final resolution, the Company will notify the Insured of the outcome in writing.

5.05. **Insurance Fraud:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
SECTION VI.
ELIGIBILITY FOR COVERAGE

6.01. Eligibility Criteria: Individuals will be accepted for coverage hereunder only upon meeting all the applicable requirements set forth below.

(a) Enrollees: To be eligible for coverage, a person must:

(1) currently be an employee or member of Group; and

(2) meet the coverage criteria mutually agreed upon by Group and the Company.

(b) Eligible Dependents: If dependent coverage is provided, the persons eligible for dependent coverage as dependents shall include:

(1) the legal spouse of any Enrollee; and

(2) any child of an Enrollee, including any natural child from the moment of birth, legally adopted child from the moment of placement in the residence of the Enrollee, or other child for whom a court holds the Enrollee responsible; and who has not yet attained the age of 26 years, or

(3) as further defined by Group.

If a dependent, unmarried child prior to attainment of the prescribed age for termination of eligibility becomes, and continues to be, incapable of self-sustaining employment because of mental or physical disability, that Eligible Dependent's coverage shall not terminate so long as he/she remains a dependent and the Enrollee's coverage remains in force; provided however, that satisfactory proof of the dependent's incapacity can be furnished to the Company within thirty (30) days of the date such Dependent's coverage would have otherwise terminated or at such other times as the Company may request proof, but not more frequently than annually.
6.02. **Documentation of Eligibility:** Persons satisfying the coverage requirements under either of the above criteria shall be eligible if:

(a) for an Enrollee, the individual's name and Social Security Number have been reported by Group to the Company in the manner provided hereunder; and

(b) in the case of changes to a Dependent's status, the change has been reported by the Group to the Company in the manner provided herein.

As stated in Section 4.04. herein, the Company may elect to inspect the Group's records in order to verify eligibility of Enrollees and Dependents. Plan Benefits will be available only to persons on whose behalf Premiums have been paid for the current period, or grace periods outlined herein in Section 4.03. If a clerical error is made, it will not affect the coverage to which the Insured is entitled under the Policy.

6.03. **Change of Participation Requirements, Contribution of Fees, and Eligibility Rules:** Composition of the Group, percentage of Enrollees covered under the Policy, and eligibility requirements are material to the Company's obligations under this Policy. During the term of this Policy, Group may not change its composition, percentage of Enrollees covered, or eligibility requirements in any way that affects the Company's obligations hereunder unless the Company consents to such change in writing. The Company may require the Group to make written request for any such change at least sixty (60) days prior to the proposed effective date of the change. Nothing herein shall limit Group's ability to add Enrollees and/or Eligible Dependents in accordance with the terms of this Policy.

6.04. **Change in Family Status:** In the event of any change in the Insured's family status [by marriage, the addition (e.g., newborn or adopted child) or deletion of dependent children, etc.], written notice in a form acceptable to the Company is to be given to the Company by the Insured, or by someone else acting on the Insured's behalf, within thirty (30) days of such change. If such notice is given, the change in the Insured's status will become effective on the first day of the month following the request for change, or at such later date as may be requested by or on behalf of the Insured. A newborn or adopted child will be covered during the thirty (30) day period after birth or adoption.
SECTION VII.
CONTINUATION OF COVERAGE

7.01. **COBRA:** The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that, under certain circumstances, health plan benefits available to an eligible Enrollee and his or her Eligible Dependents be made available for purchase by said persons upon the occurrence of a COBRA-qualifying event. If, and only to the extent that COBRA applies, the Company shall make the statutorily-required COBRA continuation coverage available for purchase in accordance with COBRA.
SECTION VIII.
CLAIMS DENIAL APPEALS AND ARBITRATION OF DISPUTES

8.01. **Claims Denial Appeals**: If, under the terms of this Policy, a claim is denied in whole or in part, a request may be submitted to the Company by Insured or Insured's authorized representative for a full review of the denial. Insured may designate any person, including his/her provider, as his/her authorized representative. References in this section to "Insured" include Insured's authorized representative, where applicable.

a) **Initial Appeal**: The request must be made within one hundred eighty (180) days following denial of a claim and should contain sufficient information to identify the Insured for whom the claim was denied, including the Enrollee's name, the Enrollee's Member Identification Number, the Insured's name and date of birth, the provider of services and the claim number. The Insured may review, during normal working hours, any documents held by the Company pertinent to the denial. The Insured may also submit written comments or supporting documentation concerning the claim to assist in the Company's review. The Company's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Insured as follows:

   Denied Claims for Services Rendered: within thirty (30) calendar days after receipt of a request for an appeal from the Insured.

b) **Second Level Appeal**: If the Insured disagrees with the response to the initial appeal of the claim, the Insured has a right to a second level appeal. Within sixty (60) calendar days after receipt of the Company's response to the initial appeal, the Insured may submit a second appeal to the Company along with any pertinent documentation. The Company shall communicate its final determination to the Insured in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

c) **Other Remedies**: When Insured has completed the appeals process stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Group should advise Insured to contact the U.S. Department of Labor or the state insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a)(1)(B)) [29 U.S.C. 1132(a)(1)(B)], Insured has the right to bring a civil action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and Insured disagrees with the outcome.
8.02. **Disputes:** Any dispute or question arising between the Company and Group or any Insured involving the application, interpretation, or performance under this Policy shall be settled, if possible by amicable and informal negotiations allowing such opportunity as may be appropriate under the circumstances for fact-finding and mediation. If any issue cannot be resolved in this fashion, it shall be submitted to arbitration.

8.03. **Procedure for Arbitration:** The procedure for arbitration hereunder shall be conducted pursuant to the Rules of the American Arbitration Association.
SECTION IX.
NOTICES

9.01. **Notices:** Any notices required under this Policy to either Group or the Company shall be in written format. Notices sent to the Group will be sent to the address or email address shown on the Group's Application unless otherwise directed by Group. Notices to the Company shall be sent to the address shown on the front page of this Policy. Notwithstanding the above, any notices may be hand-delivered by either party to an appropriate representative of the other party. The party effecting hand-delivery bears the burden to prove delivery was made, if questioned.
SECTION X.
MISCELLANEOUS

10.01. **Entire Policy:** This Policy, the Group Application, the Evidence of Coverage, and all Exhibits, addenda and attachments, and any amendments hereto, constitute the entire understanding between the parties and supersede any prior understandings and agreements between them, either written or oral. Any change or amendment to the Policy must be approved by an officer of the Company and attached hereto to be valid. No agent has the authority to change this Policy or waive any of its provisions.

10.02. **Indemnity:** The Company agrees to indemnify, defend and hold harmless Group, its shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising from the failure of the Company, its officers, agents or employees, to perform any of the activities, duties or responsibilities specified herein. Group agrees to indemnify, defend and hold harmless the Company, its members, shareholders, directors, officers, agents, employees, successors and assigns from and against any and all liability, claim, loss, injury, cause of action and expense (including defense costs and legal fees) of any nature whatsoever arising or resulting from the failure of Group, its officers, agents or employees to perform any of the duties or responsibilities specified herein.

10.03. **Liability:** Under no circumstances shall the Company or Group be liable for the negligence, wrongful acts or omissions of any doctor, laboratory, or any other person or organization performing services or supplying materials in connection with this Policy.

10.04. **Right to Reject Claims:** The Company reserves the right to reject any and all claims for services or benefits that are filed with it more than three hundred sixty-five (365) days after completion of services.

10.05. **Assignment:** Neither this Policy nor any of the rights or obligations of either of the parties hereto may be assigned or transferred, except as may be expressly authorized and provided herein, without the prior written consent of both parties hereto.

10.06. **Severability:** Should any provision of this Policy be declared invalid, the remaining provisions shall remain in full force and effect.

10.07. **Choice of Law:** While recognizing that question(s) and dispute(s) hereunder are to be resolved by arbitration, if there are any matters arising in connection with this Policy that do become the subject of legal process, the applicable law shall be that of the State of Delivery of this Policy.
10.08. **Gender:** All pronouns used herein are deemed to refer to the masculine, feminine, neuter, singular, or plural, as the identity(ies) of the person(s) may require.

10.09. **Equal Opportunity:** The Company is an Equal Opportunity and Affirmative Action employer.

10.10. **Communication Materials:** All communication materials created by Group that relate to this vision care Policy must be approved by the Company in advance of mailing to Enrollees.
EXHIBIT A

VISION SERVICE PLAN INSURANCE COMPANY
SCHEDULE OF BENEFITS
VSP Choice Plan

GENERAL
This Schedule lists the vision care benefits to which Insureds of VISION SERVICE PLAN INSURANCE COMPANY ("the Company") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Policy or Evidence of Coverage to which it is attached.

Member Doctors are those doctors who have agreed to participate in VSP's Choice Network.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are received from Non-Member Providers, the Insured is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

PLAN BENEFITS

<table>
<thead>
<tr>
<th>MEMBER DOCTOR BENEFIT</th>
<th>NON-MEMBER PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VISION CARE SERVICES</strong></td>
<td></td>
</tr>
<tr>
<td>Eye Examination</td>
<td>Covered in Full*</td>
</tr>
<tr>
<td></td>
<td>Up to $ 45.00*</td>
</tr>
</tbody>
</table>

Complete initial vision analysis that includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

*Less any applicable Copayment.
Subsequent regular eye examinations once every **plan year beginning on January 1st**.

**VISION CARE MATERIALS**

<table>
<thead>
<tr>
<th>MEMBER DOCTOR BENEFIT</th>
<th>NON-MEMBER PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lenses</strong></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>Covered in Full*</td>
</tr>
<tr>
<td></td>
<td>Up to $ 30.00*</td>
</tr>
<tr>
<td>Bifocal</td>
<td>Covered in Full*</td>
</tr>
<tr>
<td></td>
<td>Up to $ 50.00*</td>
</tr>
<tr>
<td>Trifocal</td>
<td>Covered in Full*</td>
</tr>
<tr>
<td></td>
<td>Up to $ 65.00*</td>
</tr>
<tr>
<td>Lenticular</td>
<td>Covered in Full*</td>
</tr>
<tr>
<td></td>
<td>Up to $ 100.00*</td>
</tr>
</tbody>
</table>

*Less any applicable Copayment

Available once every other **plan year beginning on January 1st**.
Frames Covered up to Plan Allowance*

Up to $ 70.00*

*Less any applicable Copayment.

Available once every other plan year beginning on January 1st.

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.
CONTACT LENSES

Contact lenses are available once every other plan year in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Insured shall not be eligible for lenses and frames again for two plan years.

NECESSARY

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Insured's Member Doctor or Non-Member Provider. Prior review and approval by the Company are not required for Insured to be eligible for Necessary Contact Lenses.

<table>
<thead>
<tr>
<th>MEMBER DOCTOR BENEFIT</th>
<th>NON-MEMBER PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Fees and Materials - Covered in Full*</td>
<td>Professional Fees and Materials - Up to $210.00*</td>
</tr>
</tbody>
</table>

ELECTIVE

<table>
<thead>
<tr>
<th>MEMBER DOCTOR BENEFIT</th>
<th>NON-MEMBER PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Materials - Up to $150.00</td>
<td>Professional Fees and Materials - Up to $105.00</td>
</tr>
<tr>
<td>Elective Contact Lens fitting and evaluation** services are covered in full once every other plan year, after a maximum $60.00 Copayment.</td>
<td></td>
</tr>
</tbody>
</table>

*Less any applicable Copayment

**15% discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.
COPAYMENT

The benefits described above are available to each Insured from any participating Member Doctor at no cost to the Insured, with the exception of any applicable Copayment as described below.

A Copayment amount of $10.00 shall be payable by the Insured to the Member Doctor at the time of the examination.

LOW VISION BENEFIT

The Low Vision benefit is available to Insureds who have severe visual problems that are not correctable with regular lenses.

<table>
<thead>
<tr>
<th>MEMBER DOCTOR BENEFIT</th>
<th>NON-MEMBER PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplementary Testing</td>
<td>Covered in Full</td>
</tr>
<tr>
<td></td>
<td>Up to $125.00*</td>
</tr>
<tr>
<td>Complete low vision analysis and diagnosis that includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.</td>
<td></td>
</tr>
<tr>
<td>Supplementary Care</td>
<td>75% of Cost</td>
</tr>
<tr>
<td></td>
<td>75% of Cost*</td>
</tr>
<tr>
<td>Subsequent low vision therapy.</td>
<td></td>
</tr>
</tbody>
</table>

Copayment

75% of the benefits payable by the Company and 25% payable by Insured.

Benefit Maximum

The maximum benefit available is $1,000.00 (excluding Copayment) every two years.

*NON-MEMBER BENEFIT

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Insured should pay the Non-Member Provider his/her full fee. The Insured will be reimbursed in accordance with an amount not to exceed what the Company would pay a Member Doctor in similar circumstances.

NOTE: There is no assurance that this amount will be within the 25% Copayment feature.
EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP’s Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

This Policy is designed to cover visual needs rather than cosmetic materials. When the Insured selects any of the following extras, the Policy will pay the basic cost of the allowed lenses or frames, and the Insured will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).
- Certain limitations on low vision care.

NOT COVERED

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals;

- Replacement of lenses and frames furnished under this Policy that are lost or broken, except at the normal intervals when services are otherwise available;

- Medical or surgical treatment of the eyes;

- Any eye examination or any corrective eyewear required by an employer as a condition of employment;

- Corrective vision treatment of an experimental nature, such as, but not limited to, RK and PRK Surgery.

THE COMPANY MAY, AT ITS DISCRETION, WAIVE ANY OF THE POLICY LIMITATIONS IF, IN THE OPINION OF THE COMPANY’S OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE INSURED.
The Company shall be entitled to receive premiums for each month on behalf of each Enrollee and his/her Eligible Dependents, if any, in the amounts specified below.

$ 5.57 per month for each eligible Enrollee without dependents.
$ 11.12 per month for each eligible Enrollee with one eligible dependent.
$ 17.93 per month for each eligible Enrollee with two or more eligible dependents.

NOTICE: The premium under this Policy is subject to change upon renewal (after the end of the initial Policy Term or any subsequent Policy Term), or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Policy.
ADDENDUM

VISION SERVICE PLAN INSURANCE COMPANY
ADDITIONAL BENEFIT RIDER
DIABETIC EYECARE PLUS PROGRAM

GENERAL

This Rider lists additional vision care benefits to which Insureds of VISION SERVICE PLAN INSURANCE COMPANY are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Program are available to Insureds who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the POLICY or Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this POLICY, pursuant to eligibility criteria established by Client:

- Enrollee.
- The legal spouse of Enrollee.
- The domestic partner of the same or opposite gender as Enrollee, any children of the domestic partner provided they depend upon the Enrollee for support and maintenance
- Any child of an Enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible.

Dependent children are covered up to age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.
PROGRAM DESCRIPTION

The Diabetic Eyecare Plus Program ("DEP Plus") is intended to be a supplement to Insureds group medical plan. Providers will first submit a claim to Insureds group medical insurance plan, and then to the Company. Any amounts not paid by the medical plan will be considered for payment by the Company. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.) If Insured does not have a group medical plan, providers will submit claims directly to the Company.

Examples of symptoms which may result in a Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- trouble focusing
- "floating" spots

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- diabetic macular edema
- rubeosis

REFERRALS

If Insured Member Doctor cannot provide Covered Services, the doctor will refer the Insured to another Member Doctor or to a physician whose offices provide the necessary services.

If the Insured requires services beyond the scope of DEP Plus, the Member Doctor will refer the Insured to a physician.

Referrals are intended to insure that Insured receive the appropriate level of care for their presenting condition. Insured do not require a referral from a Member Doctor in order to obtain Plan Benefits.
PLAN BENEFITS
MEMBER DOCTORS

COVERED SERVICES

Eye Examination: Covered in full after a Copayment of $20.00.

Special Ophthalmological Services: Covered in Full.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Insured upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

NOT COVERED

1. Services and/or materials not specifically included in this Rider as Plan Benefits.
2. Frames, lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where the Company is required by law to pay.

DIABETIC EYECARE PROGRAM DEFINITIONS

Diabetes A disease where the pancreas has a problem either making, or making and using, insulin.

Type 1 Diabetes A disease in which the pancreas stops making insulin.

Type 2 Diabetes A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.

Diabetic Retinopathy A weakening in the small blood vessels at the back of the eye.

Rubeosis Abnormal blood vessel growth on the iris and the structures in the front of the eye.

Diabetic Macular Edema Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.
ADDENDUM

VISION SERVICE PLAN INSURANCE COMPANY

VI. ELIGIBILITY FOR COVERAGE

6.01 (b) Eligible Dependents, Add the Following:

(1a) The domestic partner of the same or opposite in gender as Enrollee, pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits, and

(2b) Any d children of the domestic partner provided they depend upon the Enrollee for support and maintenance.
APPENDIX F

COORDINATION OF BENEFITS (COB)

Should a covered person be enrolled in this Plan while enrolled in any other plan providing similar benefits, Coordination of Benefits (COB) rules control whether benefits are payable under this Plan before those of the other plans. The benefits payable under this Plan will not be reduced where the COB rules provide that this Plan pays first. The benefits payable under this Plan may, however, be reduced where the COB rules provide that another plan pays first. In any case, the total of all benefits payable under all plans will not exceed 100% of the allowable expenses, and no plan will pay more than it would otherwise pay in the absence of the COB rules. There is no duplication of benefits or payment. The COB rules described in this Appendix shall control unless the applicable Summary contains COB rules, in which case the rules in the Summary will control.

If a plan does not have its own COB rules, it will be primary to this Plan (that is, it will pay benefits before this Plan does).

Even if a plan does have its own COB rules, the first of this Plan’s following COB rules to apply will determine which of the plans is primary:

1. Non-Dependent/Dependent – Any plan under which the covered person is covered as an employee, member or subscriber (that is, other than as a dependent) will pay first. Any plan under which the covered person is covered as a dependent of the employee will pay second.

2. Dependent Child/Parents Not Separated or Divorced – If a dependent child is covered under the plans of both the child’s parents, and the parents are not separated or divorced (regardless of whether they were ever married), the plan of the parent whose birth date occurs earlier in the calendar year will pay first, and the plan of the parent whose birth date occurs later in the calendar year will pay second. If the birth dates of the parents are the same, the plan which has covered a parent for the longest period of time will pay benefits before the plan of the other parent.

3. Dependent Child/Separated or Divorced Parents – Where a dependent child is covered under the plans of both parents, the parents are separated or divorced from one another, and there is otherwise no court decree setting forth the responsibility for the child’s health care costs:

   a) the plan under which the child is covered as a dependent of the custodial parent will pay first;

   b) the plan under which the child is covered as a dependent of the custodial parent’s spouse will pay second; and

   c) the plan under which the child is covered as a dependent of the noncustodial parent will pay third.
4. Active/Inactive Employee – Any plan under which the covered person is covered as an active employee (or as that employee’s dependent) will pay first. Any plan under which the covered person is covered as a laid off or retired employee (or as that employee’s dependent) will pay second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

5. Continuation Coverage – Any plan under which the covered person is covered as an employee (or as that employee’s dependent) will pay first. Any plan under which the covered person is covered under a right of continuation as provided under federal or state law (for example, under the Consolidated Omnibus Budget Reconciliation Act of 1985), will pay second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determine the order of benefits, the plan which has covered the eligible person for the longest period of time will pay first; the plan which has covered the eligible person for the shortest period of time will pay last.

**Right to Receive and Release Needed Information:** The Plan may release or receive any information needed to enforce this provision. Any person claiming benefits under this Plan must furnish the Plan with any information requested by the Plan to enforce the COB provisions in accordance with the HIPAA Privacy Requirements.

**Right to Make Payments:** Should another plan provide benefits which should have been paid by this Plan, the Plan has the right to make payment to the other plan directly. That payment will satisfy the obligation of this Plan.

**Right to Recovery:** The Plan has the right to recover from the covered person any overpayment made if the Plan was not made aware of the other available benefits.

**Coordination with Other Liability:** This Plan will pay benefits secondary to the covered person’s personal automobile insurance (including, but not limited to, no-fault insurance and uninsured motorist coverage) or other liability insurance policies through which medical payments may be made for expenses resulting from or in connection with an accidental injury.

**Coordination with Prescription Claims:** There is no coordination of benefits with prescription drugs.
APPENDIX G

NONDISCRIMINATION NOTICE

Discrimination is Against the Law
The Middlebury Health and Welfare Benefits Plan ("Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  o Qualified sign language interpreters
  o Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:
  o Qualified interpreters
  o Information written in other languages

If you need these services, contact Cheryl Mullins in Human Resources at 802-443-5442 or (cmullins@middlebury.edu).

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

The President and Fellows of Middlebury College
Attn: Cheryl Mullins
Human Resources
152 Maple Street
Suite 203
Middlebury, VT 05753
Phone: 802-443-5542
Fax: 802-443-2058
www.cmullins@middlebury.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Cheryl Mullins in Human Resources (cmullins@middlebury.edu) is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–868–1019, 800–537–7697 (TDD).
The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-802-443-5465.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-802-443-5465.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-802-443-5465.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-802-443-5465.

ध्यान दिनें: तपाईले नेपाली बोल्नुहुन्छ भने तपाईले निम्नलिङ्ग भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-802-443-5465.


ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-802-443-5465.

التحذير: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية متوفرة للجميع. اتصل بقم هاتف الصم والمكفوف 1-802-443-5465

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-802-443-5465

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-802-443-5465.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-802-443-5465.

G-2
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-802-443-5465）まで、電話にてご連絡ください。

北村：東京都港区芝浦1-802-443-5465。

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی به صورت رایگان برای شما فراهم می‌باشد. با 1-802-443-5465 تماس بگیرید。

प्रिवेस्ट सिद्द: से ड्रमी भोजन्नी घेरते दे, उं ब्राम हिंग मलकिंग मेल दुधं घोंगे रघु बुद्ध दुःखमय। 1-802-443-5465 उे वास दरे।

पुस्तका: नेपालसाहित्य संगठन, नेपालसाहित्य संगठन नेपालसाहित्य, फुटबॉलसाहित्य संगठन 1-802-443-5465।

LUS CEEV: Yog tias koj hais lus Hmooob, coward kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-802-443-5465。

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएँ उपलब्ध हैं। 1-802-443-5465 पर कॉल करें।

तीना： तुम्हारे भाषासमन्वय संगठन के लिए तैयार हैं। तुम्हारे लिए अनुवाद करें। 1-802-443-5465。