MIDDLEBURY
HEALTH AND WELFARE BENEFITS PLAN

Summary Plan Description

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 describes benefits available to Eligible Employees. A separate SPD describes benefits available solely to Eligible Retirees.

1. 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. However, certain benefits offered under the Plan are currently being run on a contract year basis pursuant to the terms of each individual benefit. 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 active Eligible Employees (as described in Section 2.1) and their beneficiaries. Eligibility for benefits varies depending upon the type of benefit being provided. As explained in Section 3.2, active Eligible Employees may pay for certain benefits on a pre-tax basis with “Salary Reduction Contributions.” Therefore, the Plan is also considered a “cafeteria plan” within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended (“Code”).

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, you, your covered spouse and dependents, have the right, at your own expense, to continue coverage that otherwise would end for the Group Health Benefits described in 3.1(a), the health care flexible spending account (“Health FSA”) benefits described in Section 3.1(b), the employee and family assistance program (“EFAP”) benefits described in 3.1(h), the vision benefits described in 3.1(i), and the group health coverage provided under the abroad assignment benefits described in 3.1(j). 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.

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 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 towards the cost of Group Health Benefits, as specified on a schedule maintained by your Employer’s Office of Human Resources (“Human Resources”).

EFAP benefits under the Plan are provided pursuant to a contract the Employer has with E4 LifeScope. Your Employer pays the full cost of coverage for EFAP benefits.

Flexible Spending Account benefits are funded entirely by Salary Reduction Contributions under the Plan, and are administered pursuant to a contract the Employer has with Business Plans Inc. (BPI). Your Employer pays the full administrative cost for the Flexible Spending Accounts.

Core life insurance benefits, core accidental death and dismemberment insurance benefits, voluntary life insurance benefits, voluntary accidental death and dismemberment insurance benefits, long-term disability insurance benefits and short-term disability insurance benefits under the Plan are provided pursuant to contracts the Employer has with UNUM. Participants are required to pay the full cost of voluntary life insurance and voluntary accidental death and dismemberment benefits, as specified on a schedule maintained by your Employer’s Office of Human Resources. Your Employer pays the entire cost of core life insurance benefits, core accidental death and dismemberment insurance benefits, short-term disability insurance benefits and long-term disability insurance benefits.
Vision benefits are provided pursuant to a contract the Employer has with Vision Service Plan Insurance company ("VSP"). The cost of such coverage is shared between active participants and the Employer.

Abroad Assignment Benefits are provided pursuant to a contract the Employer has with CIGNA International. Participants are required to contribute toward the cost of Abroad Assignment Benefits, as specified in a schedule maintained by your Employer’s Office of Human Resources.

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, 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?

(a) General requirements.

(1) **For Faculty and Staff Employees of the College and the Middlebury Institute of International Studies at Monterey (“MIIS”).** You are generally eligible to participate in the Plan if you are actively employed, are receiving compensation through your Employer’s U.S. payroll system and are classified as “benefits eligible” in the records of Human Resources, as set forth in the chart below:

<table>
<thead>
<tr>
<th>Classification</th>
<th>Org</th>
<th>FTE Range</th>
<th>Hours Per Year</th>
<th>Appointment Duration</th>
<th>Benefits Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-Time</td>
<td>College</td>
<td>.8 - 1</td>
<td>&gt;=1664</td>
<td>on-going</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>MIIS</td>
<td>.85 - 1</td>
<td>&gt;=1664</td>
<td>on-going</td>
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</tr>
<tr>
<td>Part-Time – BE</td>
<td>College</td>
<td>.48 - .79</td>
<td>1000-1663</td>
<td>on-going</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>MIIS</td>
<td>.51 - .84</td>
<td>1000-1663</td>
<td>on-going</td>
<td>Yes</td>
</tr>
<tr>
<td>Time-Limited</td>
<td>College</td>
<td>.48+</td>
<td>&gt;=1000</td>
<td>&gt;=9 months (with end date)</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>MIIS</td>
<td>.51+</td>
<td>&gt;=1000</td>
<td>&gt;=9 months (with end date)</td>
<td>Yes</td>
</tr>
<tr>
<td>Part-Time – NB</td>
<td>College</td>
<td>&lt;.48</td>
<td>&lt;1000</td>
<td>on-going</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>MIIS</td>
<td>&lt;.51</td>
<td>&lt;1000</td>
<td>on-going</td>
<td>No</td>
</tr>
</tbody>
</table>
(2) You will also be eligible if you:

(A) are considered a “full-time” employee pursuant to the look-back measurement period method for identifying full-time employees under the Patient Protection and Affordable Care Act (“ACA”) and implementing regulations and guidance issued thereunder. Full-time employee status under the ACA shall be determined pursuant to procedures maintained by Human Resources;

(B) would have been eligible pursuant to the above chart, but for the fact that you are on a sabbatical or administrative leave of absence with benefits that has been approved by the College or MIIS, and provided you remain classified as eligible for benefits in the records of Human Resources;

(C) are in a “Grant Funded” position with the College or MIIS and classified as a “benefits eligible” employee in the records of Human Resources;

(D) have been approved for “Associate Status” by the College or MIIS in accordance with procedures that are established by the College or MIIS, from time to time;

(E) have been approved for “Faculty Disability Retirement” by the College or MIIS in accordance with procedures that are established by the College or MIIS, from time to time (such coverage is limited to the medical, dental and vision care offered by the Plan);

(F) are a participant in the Employer’s Phased Retirement Program, as described in Appendix N; or

(G) are otherwise classified as a “benefits eligible” employee in the records of Human Resources, and have been approved for eligibility for benefits by the applicable insurance carrier.

(3) A Faculty Employee who would regularly have satisfied the FTE requirements for eligibility for benefits under the Plan, but for the fact that
such individual has been appointed to an administrative position at the College or MIIS, shall remain classified as a “benefits eligible” employee in the records of Human Resources, and shall remain eligible for benefits under the Plan.

(4) Notwithstanding any provision of the Plan to the contrary, except as provided in Section 2.1(a)(2)(A) above, a Faculty Employee who otherwise satisfies the eligibility requirements of this Section 2.1(a), will not be eligible for Plan benefits if the Faculty Member is not scheduled to work at least nine months during a year.

(5) For purposes of eligibility for benefits under the Plan, the term “benefits eligible” is a classification used by Human Resources to designate individuals and employment classifications which are eligible for benefits provided by the College or MIIS.

(6) For purposes of eligibility for benefits under the Plan, “active employment” generally means:

(A) on a day which is one of your scheduled work days, you are performing in the customary manner all of the regular duties of your employment on that day, either at one of the College’s or MIIS’ business establishments or at some location to which the College’s or MIIS’ business requires you to travel; a regular vacation day, properly scheduled in accordance with the normal practices and policies of the College or MIIS will qualify as a scheduled work day; or

(B) any additional requirements set forth for each individual benefit.

You will also be considered “actively employed” (i) while you are on an approved paid sabbatical or administrative leave from the College or MIIS, (ii) during academic breaks, breaks between semesters or “closure” periods during which no meals are served or interim periods between seasonal jobs, or (iii) while you otherwise remain eligible for benefits in the records of Human Resources.

(7) An “Expatriate Employee” is an individual who is working outside of the United States who is designated in records maintained by the Employer’s Office of Human Resources as an Expatriate Employee. Individuals who are classified in records maintained by the Employer’s Office of Human Resources as Expatriate Employees may, but are not required to, receive compensation through the Employer’s U.S. payroll system in order to be eligible to participate in the Plan. For the purposes of the Plan, Expatriate Employees are considered Eligible Employees, but only for
purposes of the pre-tax premium benefits described in Section 3.1(b) of the
SPD, the voluntary life insurance benefits described in Section 3.1(e)
of the SPD, and the Abroad Assignment Benefits described in Section
3.1(j) of the SPD.

Eligible Employees who are classified as Expatriate Employees may,
from time to time, have their job classifications changed by the
Employer. If you are classified as an Expatriate Employee and have your
job classification changed by your Employer such that you are no longer
classified as an Expatriate Employee, you will be able to participate in
the Plan benefits that are otherwise available to Eligible Employees. For
these purposes, the determination of your eligibility status shall be in the
sole discretion of the Office of Human Resources of the Employer.

(b) Additional Requirements. Additional requirements may apply for each
individual benefit in determining which benefit options are available to the
different categories of employees listed above and when eligibility for such option
begins. Eligibility for each individual benefit is set forth in the attached Appendix
for that benefit.

To the extent there are any inconsistencies between the eligibility provisions in the
Summaries that have been provided to you and the eligibility provisions of the Plan, the
Plan eligibility provisions will govern.

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 and/or
dependent(s) 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. Your domestic partner (as determined by documents
maintained and required by Human Resources), and any individual with whom you have
entered into a civil union, are eligible for all benefits under the Plan except the Pre-Tax
Premium Conversion, Health FSA and the Dependent Care FSA (provided all other
eligibility requirements set forth in each specific benefit are satisfied).

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 may 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 If I am an Eligible Employee, when can I participate in the Plan?

(a) For purposes of the pre-tax premium benefits, Health FSA, Dependent Care FSA, Group Health Benefits, long-term disability insurance benefits, core life insurance benefits, core accidental death and dismemberment insurance benefits, voluntary life insurance benefits, voluntary accidental death and dismemberment insurance benefits, vision benefits, and abroad assignment benefits under the Plan, you can participate on the first day of the month coincident with or next following your employment, or your classification as an Eligible Employee. As an exception, Expatriate Employees described in Section 2.1(a)(8) are eligible to participate in the Plan immediately upon hire.

(b) For purposes of the short-term disability insurance benefits, you can participate on the first day of the month coincident with or next following your classification as an Eligible Employee (subject to any additional conditions or requirements set forth in Appendix J).

(c) For purposes of the EFAP benefits, you can participate immediately upon hire.

2.4 Once I satisfy the eligibility requirements, am I automatically enrolled for the benefits offered under the Plan? Generally, no. You must execute and file an election form with the Plan Administrator. However, upon satisfying any applicable waiting periods, you are automatically enrolled for EFAP benefits, long-term disability insurance benefits, core life insurance benefits, core accidental death and dismemberment insurance benefits and short-term disability insurance benefits (no election form is required).

2.5 When must I enroll for benefits? You will be provided with information about the Plan, and with the election form for electing benefits and entering into a salary reduction agreement. If you do not enroll in the Plan within 30 days after you are first eligible, you may be denied coverage under the Plan (except that, if federal law requires a special
enrollment, such special enrollment will apply). However, once you satisfy any applicable waiting periods, you are automatically enrolled for EFAP benefits, long-term disability insurance benefits, core life insurance benefits, core accidental death and dismemberment insurance benefits and short-term disability insurance benefits.

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 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.

2.6 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 Employee, (c) the date you revoke an election form, (d) the first day for which any required contributions are not paid, (e) the date an Eligible Employee’s Active Service ends, or (f) 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 into 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, you and any 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.

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

Retirees eligible for retiree medical or dental insurance are eligible for the retirement conversion of Sick Leave Reserve (“SLR”), if applicable.

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 you, your covered spouse, covered domestic partner and covered dependents (collectively, “Covered Persons”), until the end
of the month in which the last SLR day is used. The Employer will pay the cost of the retiree medical 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.

2.8 **Will I have continued benefits under the Plan if I am disabled?** If you are an eligible employee, you generally will continue to be eligible for Plan benefits for a maximum of twenty-six weeks if you are unable to work due to a disability, provided the terms of each individual benefits allow for such continued coverage. Certain situations may allow you to continue to be eligible for Plan benefits for a period longer than twenty-six weeks, as determined by your Employer, provided you remain eligible for Plan benefits in accordance with Section 2.1. Faculty Employees should refer to applicable provisions in the Faculty Handbook.

### III. BENEFITS AND CONTRIBUTIONS

3.1 **What benefits are offered by the Plan?**

(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, and the remainder of this SPD. Summaries of the different Group Health Benefits have been attached as Appendices C and D 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) **Flexible Spending Accounts.**

Your Employer offers Health FSA and the Dependent Care FSA (collectively, the “FSAs”) in accordance with the general terms stated in the attached Appendices E
and F, respectively, and the remainder of this SPD. Contribution requirements are described in Appendix B.

The terms and conditions of these FSAs, including but not limited to contracts with 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.

(c) **Pre-Tax Premium Conversion.** *(See Section 3.2 below).*

(d) **Group Core Life Insurance and Core Accidental Death & Dismemberment Insurance.**

Your Employer offers group core life insurance and core accidental death & dismemberment insurance (collectively, “Core Life Insurance Benefits”) in accordance with the terms stated in Appendix G and the remainder of this SPD. A summary of the Core Life Insurance Benefits has been attached as Appendix G 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. 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.

(e) **Group Voluntary Life Insurance and Voluntary Accidental Death & Dismemberment Insurance.**

Your Employer offers group voluntary life insurance and voluntary accidental death & dismemberment insurance benefits (“Voluntary Life Insurance Benefits”) in accordance with the terms stated in Appendix H and the remainder of this SPD. A summary of the Voluntary Life Insurance Benefits has been attached as Appendix H 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. 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.

(f) **Long-Term Disability Insurance.**
Your Employer offers long-term disability insurance benefits in accordance with the terms stated in Appendix I and the remainder of this SPD. A summary of the long-term disability insurance has been attached as Appendix I 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 Employee 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.

(g) **Short-Term Disability Insurance.**

Your Employer offers short-term disability insurance benefits in accordance with the terms stated in Appendix J and the remainder of this SPD. A summary of the short-term disability insurance has been attached as Appendix J 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 Employee 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.

(h) **Employee and Family Assistance Program Benefits.**

Your Employer offers EFAP benefits in accordance with the terms stated in Appendix K and the remainder of this SPD. Information describing the EFAP benefit has been attached as Appendix K of this SPD, and additional copies may be obtained from Human Resources. Contribution requirements are described in Appendix B.

The terms and conditions of these benefits, including but not limited to contracts and policies, 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.

(i) **Vision Benefits.**
Your Employer offers vision benefits in accordance with the terms stated in Appendix L and the remainder of this SPD. A summary of the vision benefits has been attached as Appendix L 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 Employee 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.

(j) Abroad Assignment Benefits.

Your Employer offers Abroad Assignment Benefits in accordance with the terms stated in Appendix M and the remainder of this SPD. The Abroad Assignment Benefits include medical, dental, life and accidental death and dismemberment insurance, long term disability, and emergency medical evacuation/repatriation benefits. A summary of the Abroad Assignment Benefits has been attached as Appendix M 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 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.

(k) Phased Retirement Benefits.

Your Employer offers Phased Retirement Program benefits in accordance with the terms stated in Appendix N and the remainder of this SPD. Information regarding the Phased Retirement Program has been attached as Appendix N to this SPD. The Phased Retirement Program provisions set forth in Appendix N supersede certain otherwise applicable provisions set forth in this SPD.

3.2 How is the cost of Plan benefits paid for active Eligible Employees? You and your Employer each currently pay a share of the premiums for Group Health Benefits you have elected, as stated in Appendix B. Core life insurance benefits, core accidental death and dismemberment insurance benefits, EFAP benefits, short-term disability insurance benefits and long-term disability insurance benefits are paid for entirely by your Employer for Eligible Employees. You are required to pay the full cost of any voluntary life insurance benefits, voluntary accidental death and dismemberment insurance benefits or
Flexible Spending Account benefits you elect. (Your Employer pays the full administrative cost for the Flexible Spending Accounts.)

Expatriate Employees pay for Abroad Assignment Benefits in accordance with a schedule of required contributions that is available from Human Resources.

You may choose to reduce your taxable compensation in order to pay your share of the Group Health Benefit premiums with pre-tax dollars. These pre-tax amounts are referred to as “Salary Reduction Contributions.” You may also elect Salary Reduction Contributions to be reimbursed for eligible expenses under the FSAs on a pre-tax basis.

The advantage of paying your share with Salary Reduction Contributions is that you do not pay federal or state income taxes, or Social Security (FICA) taxes, on these contributions. Therefore, you receive higher take-home pay.

A schedule of required contributions for all Plan benefits is available from Human Resources.

Note: Premiums for voluntary life insurance benefits and voluntary accidental death and dismemberment insurance benefits must be paid with after-tax dollars.

3.3 Are contributions required to be made during approved leaves of absence? If you are on an approved leave of absence that would not otherwise cause a loss of coverage under the Plan (or in any other circumstance where payroll deductions cannot be made), you must agree to pay your share of premiums for the benefits you have elected. While not being paid: (i) you may keep your benefits if you agree in advance to have your Employer recover the amount due through “catch up” pay reductions when you return; (ii) you may choose to revoke your benefit elections; (iii) you may pay for your benefits with after-tax dollars, or (iv) you may arrange to “pre-pay” with pay reductions. If you fail to pay such required contributions within the time frame established by the Plan Administrator, your coverage will be retroactively terminated as of the first day of the period for which no contributions are received by the Plan Administrator, unless otherwise required under the COBRA rules.

3.4 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 O.
IV. ELECTIONS

4.1 When and how do I elect benefits and Salary Reduction Contributions? When you first become an active Eligible Employee and during subsequent election periods (as described in Section 4.3(b) below), you may choose the benefits you want, and if you have not specifically designated how such premiums are to be paid, you will automatically be enrolled for the Pre-Tax Premium Conversion benefit that corresponds with your enrollment.

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?

(a) First Election Period. You must return an election form within 30 days after you are first eligible to elect the benefits you want, and to choose whether to pay premiums with Salary Reduction Contributions (on a prospective basis). If you do not return the forms in a timely manner, you will be deemed to have elected to receive your full compensation. You will, however, be automatically enrolled for core life insurance benefits, core accidental death and dismemberment insurance benefits, EFAP benefits, short-term disability insurance benefits and long-term disability insurance benefits (at no cost to you) provided you are eligible for such benefits.

If you enroll for a benefits option that allows for premiums to be paid on a pre-tax basis, but you have not specifically designated how such premiums are to be paid (for example, either pre-tax or after-tax), you will be automatically enrolled for the Pre-Tax Premium Conversion benefit that corresponds with your enrollment.

This is your “deemed election.” You will not be enrolled for any other Plan benefits.

(b) Subsequent Election Periods:

(1) Dependent Care and Health FSAs. If you do not submit an election form, you will be deemed to have elected not to participate in the FSAs. No further Salary Reduction Contributions will be made for these benefits.

(2) All Other Plan Benefits. If you do not submit an election form during the open enrollment period for a subsequent Plan Year, your prior election or deemed election regarding Plan benefits will remain in effect. This means you will have the same benefit coverage (if any) that you had on the last day of the previous Plan Year. You will be required to pay your share of the premiums that apply during the new Plan Year (with Salary Reduction Contributions, as previously elected).
4.4 **May I change an election after the Plan Year has begun?** You are not allowed to change (make, revoke or modify) an election once a Period of Coverage has begun (Plan Year or remainder for new Participant), except as permitted by the IRS rules, a 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 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 on an individual who did not meet the definition of dependent under the plan AND/OR disciplinary action. 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.

**Please note:** For purposes of the Health FSA, no election changes will be allowed unless there is at least one payroll period remaining in the Period of Coverage.

**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 during a Period of Coverage 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** (or number of qualifying dependents for the Dependent Care FSA);
(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.

(vi) Reduction in hours of service, by you such that your employment status changes from being reasonably expected to average 30 hours of service per week to reasonably expected to average less than 30 hours of service per week regardless of whether the reduction would result in a loss of coverage and your election change corresponds with intended enrollment in another plan that provides minimum essential coverage that is effective no later than the first day of the second month following the month that includes the change. This status change does not apply to the FSAs.

(vii) Enrollment in a Qualified Health Plan, provided that the Qualified Health Plan is obtained through a Marketplace and the revocation of coverage corresponds to the intended enrollment in Marketplace coverage that is effective no later than the day immediately following the last day the coverage is revoked. This status change does not apply to the FSAs.

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.

Special Rules after a Termination of Employment: If the change in employment status is your termination of employment (or other loss of eligibility), your election of benefits is revoked automatically, except that:

* You may choose to continue your Group Health Benefits coverage under the COBRA rules, at your own expense. The COBRA rules also may allow you to continue Health FSA coverage for the remainder of the year, depending upon the facts, as explained in Article V. Unless you may continue the Health FSA coverage under those rules and elect to do so, you may not be reimbursed for expenses incurred after your termination. Any previously contributed amounts that can’t be applied to expenses incurred before your termination will be forfeited.

Special Rules during an “FMLA” or Other Authorized Leave: If the change in employment status is an authorized leave under the Family and Medical Leave Act or for other reasons, any pay you are still due will be reduced for benefits as if you were working.
While not being paid: (i) you may keep your benefits if you agree in advance to have your Employer recover the amount due through “catch up” pay reductions when you return; (ii) you may choose to revoke your benefit elections, (iii) you may pay for your benefits with after-tax dollars, or (iv) you may arrange to “pre-pay” with pay reduction.

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.

As one example, if you gain eligibility for coverage under a family member’s group medical plan, your election to cancel such coverage under this Plan will satisfy the consistency requirement only if you actually enroll in the other plan.

Cost or Coverage Changes for Benefits: Except for the Health FSA, you may change an election during a Period of Coverage if the cost of a benefit changes, or if there is a change in benefit coverage (in some instances your Salary Reduction Contributions will be automatically increased or decreased to account for any change in benefit cost). In part, these rules for benefits other than the Health FSA now allow an appropriate election change when another family member is making an election change under an employer plan with a different period of coverage.

Also, these rules treat a change in your dependent care provider as a coverage change for the Dependent Care FSA. Unless the provider is a relative, such an election also may be changed for a change in provider cost. For example, if a relative replaces an outside provider, Salary Reduction Contributions may be changed appropriately. However, if the relative later increases the rates charged, you may not increase the contributions to pay for that increase.

Changes Based on Medicare or Medicaid Entitlement: You may make a change during a Period of Coverage 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 during a Period of Coverage 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.

The Plan Administrator also has the right to reject, revoke or modify your election of Salary Reduction Contributions, and thereby treat your premium payments as taxable compensation, to the extent necessary to comply with certain legal rules that apply to the Plan. Normally, these rules apply only to a “highly compensated employee,” as that term is defined in the Internal Revenue Code.
In the event that you fail to make the required contributions and your coverage or benefits are canceled, you will not be able to make a new election for the remaining portion of the Plan Year.

4.5 **How will my Social Security benefits be affected?** Unlike after-tax contributions, Salary Reduction Contributions are not subject to Social Security taxes. Therefore, your Social Security benefits may be reduced if you elect these contributions. Generally, the reduction will be small. However, the impact will vary from person to person and cannot be predicted by your Employer.

4.6 **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.

4.7 **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 amount of participant contributions, as well as contributions made by your Employer, for the provision of certain benefits 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. 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 cost 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:

- there will be a payroll adjustment to the participant contribution for the domestic partner’s or individual with whom you have entered into a civil union’s benefit coverage so that such contribution will be made on an after-tax basis; and
• your Employer’s contribution for this coverage will be reported as additional compensation to you. Your Employer will be required to withhold applicable state and federal taxes from your pay 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 Employee, or you fail to pay any required premiums. However, under federal law, continued health coverage may be available for you, 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 following benefits provided under the Plan are subject to COBRA: the Group Health Benefits described in 3.1(a), the health care flexible spending account (“Health FSA”) benefits described in Section 3.1(b), the employee and family assistance program (“EFAP”) benefits described in 3.1(h), the vision benefits described in 3.1(i), and the group health coverage provided under the abroad assignment benefits described in 3.1(j).

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 you and your family other than COBRA coverage through the Plan. Beginning January 1, 2014, you and your family will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you may be eligible for a tax credit that lowers your monthly premium. You and your family 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 your 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 you 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 you or 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 Participant To Elect COBRA Coverage.** You may elect health continuation coverage for yourself and covered family members, if coverage is lost because of a reduction in hours of employment or termination of employment, for reasons other than gross misconduct on your part. This is referred to as a “Termination-of-Employment Qualifying Event.”

(c) **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 Termination-of-Employment Qualifying Event;

(ii) your death;

(iii) your spouse’s divorce or legal separation from you; or

(iv) your entitlement to Medicare.

(d) **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 Termination-of-Employment Qualifying Event;

(ii) 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.

(e) **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 (a), 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.

(f) **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, except as provided for costs during a “disability extension period” as explained below. 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.

(g) **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.

- A Qualified Beneficiary may continue health coverage for 18 months in the event of a Termination-of-Employment Qualifying Event. However, the 18-month coverage period for that event may be extended to 36 months, for covered spouses and dependent children, if another Qualifying Event occurs during the initial 18-month period (or during the disability...
If a Qualified Beneficiary wishes to extend coverage due to a second Qualifying Event, the Qualified Beneficiary, or a legal representative, must notify your Employer’s Human Resource Office, in writing, within 60 days after the second Qualifying Event occurs.

Note: Your entitlement to Medicare will not be a Qualifying Event for family members if they still have health coverage because you are still actively employed. However, if family members later lose Plan coverage due to a Termination-of-Employment Qualifying Event, their COBRA coverage period will be the 36-month period measured from the date you became entitled to Medicare, if that is longer than the 18-month period measured from the Termination-of-Employment Qualifying Event.

(h) Extension For Disabled Individuals and Increased Premium:

(i) The 18-month period for a Termination-of-Employment Qualifying Event may be extended from 18 to 29 months for all Qualified Beneficiaries entitled to COBRA coverage on the basis of that event, if any of them receives a determination of disability by the Social Security Administration that he or she became disabled within 60 days of the Qualifying Event. Your Employer’s Human Resource Office must be notified of the determination of disability, in writing, within 60 days after the determination date and before the first 18 months of COBRA coverage ends.

(ii) During a disability extension period, the Plan may charge up to 150% of the premium as long as the disabled Qualified Beneficiary is part of the covered group. This higher limit applies if the 29-month period is extended to 36 months on the basis of another Qualifying Event that occurs during the disability extension period.

(i) 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.

(j) 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;

(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) if the disability extension applies, there is a final determination that the Qualified Beneficiary is no longer disabled under the Social Security Act. Your Employer must be notified within 30 days of the date of any final determination that the disability has ended. The extended health coverage will be terminated in the month that begins more than 30 days after the date of the final determination that the Qualified Beneficiary is no longer disabled.

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.

5.3 What is the survivors’ COBRA benefit? Employees enrolled in Plan medical or dental benefits have a survivor’s benefit. If you die while in active employment, then your enrolled survivors will be eligible for a subsidized COBRA benefit, as described below:

1. For sixty (60) days following the date of death, all COBRA premiums will be paid by the Employer.

2. Following those sixty (60) days, accumulated Sick Leave Reserve will be converted to insured days (weekends and holidays listed in the Employee Handbook will not count). For each insured day, the Employer will pay 100% of the COBRA premium to continue the medical and dental insurance coverage.

3. If survivors pay on a monthly basis 75% of the full COBRA premium, for the balance of one year following the sixty (60) days and Sick Leave Reserve, the Employer will pay 25% of the COBRA premium.

4. If survivors pay on a monthly basis 100% of the full COBRA premium, COBRA coverage will continue until COBRA eligibility ends.
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<td>0</td>
</tr>
<tr>
<td>Balance of one year from date of death of Eligible Employee, then</td>
<td>25</td>
<td>75</td>
</tr>
<tr>
<td>From end of 1st year to end of COBRA eligibility</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

5.4 **When is COBRA Coverage offered with respect to the Health FSA?** COBRA coverage will be provided with respect to coverage under the Health FSA only if, as of the date of the Qualifying Event, the maximum benefit to which a Qualified Beneficiary could become entitled under the Health FSA during the remainder of the Plan Year (by electing the COBRA coverage) is greater than the maximum amount that the Plan may require to be paid for that COBRA coverage (“COBRA Premium”) for the remainder of the Plan Year.

**Example:** If you elect $600 of coverage under the Health FSA for a Plan Year and terminate employment on August 31, you will have contributed $400 ($50 monthly for 8 months) for Health FSA coverage. If you have only incurred $100 of reimbursable expenses as of August 31, you will be offered COBRA coverage because the COBRA Premium for the rest of the Plan Year is $204 (102% of $200), which is less than the $500 maximum benefit ($600 - $100) that is available for expenses incurred after August 31, by electing COBRA coverage.

If you had incurred $400 of reimbursable expenses as of August 31, COBRA coverage would not be offered because the maximum benefit for the rest of the Plan Year is only $200 ($600 - $400), which is less than the $204 COBRA Premium.

If provided, the COBRA coverage for the Health FSA applies only for the Plan Year in which the Qualifying Event occurs. With this exception, the other COBRA rules in this Article V are applicable.
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 determination. 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.

(f) **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, EFAP and/or Health FSA 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 benefits.

XI. MEDICARE

You, your covered spouse and your covered dependents (collectively, “Covered Persons”), age sixty-five (65) and over, will be provided with coverage under this Plan on the same basis as available to Covered Persons under the age of sixty-five (65). Due to your current employment status, the Plan will be the primary payer of benefits and Medicare, if elected, will be the secondary payer of benefits.

Each Participant over the age of sixty-five (65) has the right to reject the Employer-provided group health plan and elect to have Medicare as their only coverage. Should the Participant elect this option, Medicare will become the Participant’s only health insurance coverage and will be the primary payer of benefits.

For a Covered Person, if Medicare eligibility is due solely to end-stage renal disease (“ESRD”), the Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, Medicare will be primary payer of benefits and the Plan will be secondary.

This provision will comply with the Social Security Act as amended from time to time.

Medicare Carve Out Provisions

Medicare Carve Out applies to Participants who are no longer actively employed due to disability (during the time they remain on the Plan) and Medicare is the primary payer, to the extent permitted under federal law. Carve out complements Medicare by providing payment for expenses not paid by Medicare. Payment is determined by the design of the medical insurance coverage.
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 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 disabled Covered Person 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 the Employer is obligated by law to have this Plan pay its benefits before Medicare covers the health care services provided to the Participant or Dependent.
APPENDIX A

AFFILIATED EMPLOYERS PARTICIPATING IN THE PLAN

There are no Affiliated Employers currently participating in the Plan.
I. **GROUP HEALTH BENEFITS**

Each Eligible Employee may elect coverage under the Medical Insurance Plan and Dental Insurance Plan, in accordance with Appendices C and D respectively. The cost of such coverage elected is shared between your Employer and the Eligible Employee.

The actual dollar amount of the required premiums for the coverage elected each Plan Year will be communicated to Participants during the annual Open Enrollment Period before the Plan Year begins. In addition, Plan changes may require contribution rate changes 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. **HEALTH FSA PLAN**

Each Eligible Employee may elect coverage under the Health FSA, in accordance with Appendix E.

The Health FSA is entirely funded by Salary Reduction Contributions. Your Employer pays the full administrative costs for the Health FSA.

III. **DEPENDENT CARE FSA PLAN**

Each Eligible Employee may elect coverage under the Dependent Care FSA, in accordance with Appendix F.

The Dependent Care FSA is entirely funded by Salary Reduction Contributions. Your Employer pays the full administrative costs for the Dependent Care FSA.

IV. **CORE LIFE INSURANCE PLAN BENEFITS**

Eligible Employees are automatically enrolled for core life insurance and core accidental death and dismemberment plan coverage, in accordance with Appendix G. Your Employer pays the entire cost of such coverage.
V. **VOLUNTARY LIFE INSURANCE PLAN BENEFITS**

Eligible Employees may elect voluntary life insurance and voluntary accidental death and dismemberment insurance coverage, in accordance with Appendix H, at full cost to the Eligible Employee.

VI. **LONG-TERM DISABILITY PLAN BENEFITS**

Eligible Employees are automatically enrolled for Long-Term Disability Plan Benefits, in accordance with Appendix I. Your Employer pays the entire cost of such coverage.

VII. **SHORT-TERM DISABILITY PLAN BENEFITS**

Eligible Employees are automatically enrolled for Short-Term Disability Plan Benefits, in accordance with Appendix J. Your Employer pays the entire cost of such coverage.

VIII. **EMPLOYEE AND FAMILY ASSISTANCE PROGRAM BENEFITS**

Eligible Employees are automatically enrolled for EFAP benefits under the Plan. The EFAP benefits are provided in accordance with Appendix K. The Employer pays the full cost of coverage for EFAP benefits under the Plan.

IX. **PRE-TAX PREMIUM BENEFITS**

Eligible Employees may elect to have Salary Reduction Contributions made to pay premiums for Group Health Benefits, Vision Benefits and for benefits under the Dependent Care FSA and the Health FSA.

If you enroll for a benefits option that allows for premiums to be paid on a pre-tax basis, but you have not specifically designated how such premiums are to be paid (for example, either pre-tax or after-tax), you will be automatically enrolled for the Pre-Tax Premium Conversion benefit that corresponds with your enrollment.

X. **VISION BENEFITS**

Eligible Employees may elect Vision Benefits, in accordance with Appendix L. The cost of such coverage elected is shared between the Employer and the Eligible Employee.

XI. **ABROAD ASSIGNMENT BENEFITS**

Expatriate Employees may elect Abroad Assignment Benefits, in accordance with Appendix M. The cost of such coverage is shared between the Employer and the Expatriate Employee.
The actual dollar amount of the required premiums for the coverage elected each Plan Year will be communicated to Participants during the annual Open Enrollment Period before the Plan Year begins. In addition, Plan changes may require contribution rate changes 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.

XII. PHASED RETIREMENT BENEFITS

Eligible employees may participate in the Phased Retirement Program, in accordance with Appendix N.
Middlebury

PREFERRED PROVIDER MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2017

ASO1
3339660

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.
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.
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 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.
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 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 and 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).


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. Đành cho khách hàng hiện tại của Cigna, gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1-800-244-6224 (TTY: Quay số 711).

Korean

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

Tagalog

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

Russian

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

Arabic

Cigna تقدم خدمات الترجمة المجانية لجميع عملائها الحاليين، في حالات الاتصال بالرقم المدون عليه في بطاقتك الشخصية أو الاتصال ب 1-800-244-6224 (TTY: 711).

French Creole

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

French

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

Portuguese

ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de
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

<table>
<thead>
<tr>
<th>Assistant Surgeon and Co-Surgeon Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assistant Surgeon</strong></td>
</tr>
<tr>
<td>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.)</td>
</tr>
<tr>
<td><strong>Co-Surgeon</strong></td>
</tr>
<tr>
<td>The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td><strong>The Percentage of Covered Expenses the Plan Pays</strong></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>Not Applicable</td>
<td>200%</td>
</tr>
</tbody>
</table>

Maximum Reimbursable Charge is determined based on the lesser of the provider’s normal charge for a similar service or supply; or

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:

- 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 the Insurance Company.

**Note:**
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.

**Note:**
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.
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></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><strong>Family Maximum Calculation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Individual Calculation:</strong></td>
<td>Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.</td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></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><strong>Family Maximum Calculation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Individual Calculation:</strong></td>
<td>Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.</td>
<td></td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>--------------------------------------</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>Note: OB/GYN providers will be considered either as a PCP or Specialist.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery Performed in the Physician’s Office</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>Second Opinion Consultations (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>Allergy Treatment/Injections</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>Allergy Serum (dispensed by the Physician in the office)</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>Medical Telehealth</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>
</tr>
<tr>
<td>--------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: 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>Routine Preventive Care - all ages</td>
<td>100%</td>
<td>100%</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>100%</td>
<td>100%</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% Limited to the semi-private room negotiated rate</td>
<td>Plan deductible, then 80% 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>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Surgeon, Radiologist, Pathologist, Anesthesiologist</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>
<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>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Urgent Care Facility or Outpatient Facility</td>
<td></td>
<td></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></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 UC visit</td>
<td>80%</td>
<td>80%</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>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</td>
<td></td>
<td></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>
<td>---------------------------------</td>
<td>---------------------------------</td>
</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: 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>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>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></td>
<td></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>
</tbody>
</table>
### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>MATERNITY CARE SERVICES</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Visit to Confirm Pregnancy</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Note:</strong> 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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ABORTION</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<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>
<td>------------</td>
<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><strong>Note:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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>
</tbody>
</table>
### BENEFIT HIGHLIGHTS

#### Infertility Treatment
Coverage will be provided for the following services:
- Testing and treatment services performed in connection with an underlying medical condition.
- Testing performed specifically to determine the cause of infertility.
- Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).
- Artificial Insemination, In-vitro, GIFT, ZIFT, etc.

<table>
<thead>
<tr>
<th>Physician’s Office Visit (Lab and Radiology Tests, Counseling)</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<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>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>Lifetime Maximum: $15,000 per member</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Organ Transplants
Includes all medically appropriate, non-experimental transplants

| Primary Care Physician’s Office Visit                          | 80%         | 80%            |
| Specialty Care Physician’s Office Visit                       | 80%         | 80%            |
| 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 specific organ transplant maximum: |
| Travel Maximum: $10,000 per transplant                        | 100% (only available when using Lifesource facility) | In-Network coverage only |

Includes all medically appropriate, non-experimental transplants
- Heart - $150,000
- Liver - $230,000
- Bone Marrow - $130,000
- Heart/Lung - $185,000
- Lung - $185,000
- Pancreas - $50,000
- Kidney - $80,000
- Kidney/Pancreas - $80,000
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td><strong>Breast Feeding Equipment and Supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Includes the rental of one breast pump</td>
<td>100%</td>
<td>100%</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><strong>External Prosthetic Appliances</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum: Unlimited</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td><strong>Nutritional Evaluation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum: 3 visits per person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>however, the 3 visit limit will not apply to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>treatment of mental health and substance use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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><strong>Dental Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to charges made for a continuous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>course of dental treatment started within</td>
<td></td>
<td></td>
</tr>
<tr>
<td>six months of an injury to sound, natural</td>
<td></td>
<td></td>
</tr>
<tr>
<td>teeth.</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>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<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>
</tr>
<tr>
<td>Acupuncture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlimited</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Lifetime Maximum:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$2,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Resulting From Life Threatening Emergencies</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Includes Acute Inpatient and Residential Treatment</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>Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient - Office Visits</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Includes individual, family and group psychotherapy; medication management, Behavioral Telehealth consultation, etc.</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>Outpatient - All Other Services</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Includes Partial Hospitalization, Intensive Outpatient Services, Behavioral Telehealth consultation, etc.</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>BENEFIT HIGHLIGHTS</td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>Plan deductible, then 80%</td>
<td>Plan deductible, then 80%</td>
</tr>
<tr>
<td>Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential 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>
<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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<tr>
<td>Calendar Year Maximum: Unlimited</td>
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<tr>
<td>Outpatient - All Other Services</td>
<td>80%</td>
<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.

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

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

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.

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 anesthetic 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:
• the investigational drug, item, device, or service, itself; or
• 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.

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Orthognathic Surgery

- orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not 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.

Home Health Services

- charges made for Home Health Services when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility.

Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals.

A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by 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 even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

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;
• for any curative or life-prolonging procedures;
• to the extent that any other benefits are payable for those expenses under the policy;
• for services or supplies that are primarily to aid you or your Dependent in daily living.

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 provided with 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 association 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, wheel chairs, 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 posturepedic 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.

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**External Prosthetic Appliances and Devices**

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

**Prostheses/Prosthetic Appliances and Devices**

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

**Orthoses and Orthotic Devices**

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses;
  - semirigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.

- 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 plagiocephaly. 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 bras 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**

<table>
<thead>
<tr>
<th>Tier 1</th>
<th>The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy</th>
<th>The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs on the Prescription Drug List</td>
<td>No charge after $10 copay</td>
<td>In-network coverage only</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>NETWORK PHARMACY</td>
<td>NON-NETWORK PHARMACY</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td><strong>Tier 2</strong></td>
<td>No charge after $25 copay</td>
<td>In-network coverage only</td>
</tr>
<tr>
<td>Brand Drugs designated as preferred on the Prescription Drug List</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tier 3</strong></td>
<td>No charge after $40 copay</td>
<td>In-network coverage only</td>
</tr>
<tr>
<td>Brand Drugs designated as non-preferred on the Prescription Drug List</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drug Products at Retail Designated Pharmacies</strong></td>
<td><strong>The amount you pay for up to a consecutive 90-day supply at a Designated Pharmacy</strong></td>
<td><strong>The amount you pay for up to a consecutive 90-day supply at a non-Designated Pharmacy</strong></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tier 1</strong></td>
<td>No charge after $20 copay</td>
<td>In-network coverage only</td>
</tr>
<tr>
<td>Generic Drugs on the Prescription Drug List</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tier 2</strong></td>
<td>No charge after $50 copay</td>
<td>In-network coverage only</td>
</tr>
<tr>
<td>Brand Drugs designated as preferred on the Prescription Drug List</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tier 3</strong></td>
<td>No charge after $80 copay</td>
<td>In-network coverage only</td>
</tr>
<tr>
<td>Brand Drugs designated as non-preferred on the Prescription Drug List</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Infertility medications have a $4,000 Lifetime maximum All contraceptives are covered at No charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drug Products at Home Delivery Pharmacies</strong></td>
<td><strong>The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy</strong></td>
<td><strong>The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy</strong></td>
</tr>
<tr>
<td><strong>Tier 1</strong></td>
<td>No charge after $20 copay</td>
<td>In-network coverage only</td>
</tr>
<tr>
<td>Generic Drugs on the Prescription Drug List</td>
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<tr>
<td>Tier 3</td>
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<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, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. When considering a Prescription Drug Product for tier placement on the Prescription Drug List or other coverage conditions, 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 the 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 status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). Please access the Internet through the website shown on your ID card or call member services at the telephone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

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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.

**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.

**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

**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.
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; Rolfing; 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

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“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 biologicals 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. However, when Medicare coverage is due to disability, 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
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.

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 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.

Rescissions
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.

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 arsphenamine or derivative of arsphenamine (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).

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

**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.

**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**
Dependants 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.

Expense Incurred

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

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.

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.

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.

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.

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.
**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.

HC-DFS16 04-10 V1

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.

HC-DFS848 10-16

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.

HC-DFS839 10-16

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

HC-DFS17 04-10 V1

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.

HC-DFS21 04-10 V1

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.

HC-DFS849 10-16

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.

**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.

**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/GlucaGen, injection aids, insulin pump accessories (but excluding 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.

**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.

**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.

**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
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.

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 Pharmacy by third parties. The Usual and Customary (U&C) Charge includes a dispensing fee and any applicable sales tax.
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, 800-537-7697 (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:** Cố dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Dành cho khách hàng hiện tại của Cigna, gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1-800-244-6224 (TTY: Quay số 711).

Korean

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

Tagalog

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

Russian

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

Arabic

Cigna يرجى الانتباه خدمات الترجمة المجانية متاحة لكم. في الحالات يرجى الاتصال بالرقم المدون على طائرتك الشخصية، أو اتصل ب 1-800-244-6224 (TTY: Rele 711). 

French Creole

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

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.

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>PARTICIPATING PROVIDER</th>
<th>NON-PARTICIPATING PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classes I, II, III, IX Combined Calendar Year Maximum</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Class IV Lifetime Maximum</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>PARTICIPATING PROVIDER</td>
<td>NON-PARTICIPATING PROVIDER</td>
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<td><strong>Calendar Year Deductible</strong></td>
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<td></td>
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<tr>
<td>Individual</td>
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<td>$25 per person</td>
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<tr>
<td></td>
<td></td>
<td>Not Applicable to Class I</td>
</tr>
<tr>
<td>Family Maximum</td>
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<td>Not Applicable</td>
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<td></td>
<td></td>
<td>Not Applicable to Class I</td>
</tr>
<tr>
<td><strong>Class I</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
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<td>100%</td>
</tr>
<tr>
<td><strong>Class II</strong></td>
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<td></td>
</tr>
<tr>
<td>Basic Restorative</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
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<tr>
<td><strong>Class III</strong></td>
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<tr>
<td>Major Restorative</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
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<tr>
<td><strong>Class IV</strong></td>
<td></td>
<td></td>
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<tr>
<td>Orthodontia</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td><strong>Class IX</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implants</td>
<td>80% after plan deductible</td>
<td>80% after plan deductible</td>
</tr>
</tbody>
</table>
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
Crowns
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-Fourths 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.

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.

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.
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.

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 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.

**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, insurance carrier or other party has been notified.
- 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 for 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 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.

**Coinsurance**
The term Coinsurance 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**
Dependants 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.

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.
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.

Maximum Reimbursable Charge - Dental
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 policyholder-selected 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 percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

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.

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.
APPENDIX E

HEALTH FLEXIBLE SPENDING ACCOUNT

INTRODUCTION

Middlebury sponsors the Health Flexible Spending Account ("Health FSA"), which allows you to set aside money for non-reimbursed healthcare expenses on a pre-tax basis. As you incur healthcare expenses throughout the year, you can get reimbursed with tax-free dollars from your FSA. With an FSA, every dollar you set aside saves you taxes and increases your spendable income. You elect to have your annual contribution deducted from your paycheck each pay period, in equal installments throughout the year – before federal income, state income (in most cases) and Social Security taxes are taken out. Using these accounts can be a valuable tool for budgeting and saving tax money.

PLAN ADMINISTRATION

Effective January 1, 2017 Middlebury’s Health FSA is administered by Business Plans, Inc. (BPI), through their “MyCafeteriaPlan” FSA service.

PLAN ENROLLMENT

Unless otherwise noted, coverage becomes effective the first of the month after (or coincident with) the employee and/or dependents entering eligible status.

Eligible Employees, as defined in Section 2.1, are allowed to participate in the FSA. Enrolled Eligible Employees may use this Health FSA to cover expenses incurred by their eligible Spouses and Dependents. (See Article II for full information on eligibility.)

You must enroll for coverage within thirty (30) days of your eligibility date; otherwise you must wait until the next annual Open Enrollment Period to enroll. There will be an annual Open Enrollment Period prior to the beginning of each Plan Year. The effective date of coverage will be January 1 of the following year.

HEALTH FSA PLAN DETAILS

Expenses that are eligible for reimbursement through the Health FSA include out-of-pocket expenses incurred by you or your Spouse or children (until the end of the calendar year in which the child reaches age 26), and any Dependent that you would otherwise be able to claim on your federal income tax return. This applies even if you and/or your Dependents are not insured through the Middlebury medical, dental, or vision insurance plans.

If you elect to participate in the Health FSA, Middlebury will establish an account on your behalf. The amount you elect to contribute for the Plan Year will be pro-rated and deducted on a pre-tax
basis (before federal, state, and FICA taxes) from each paycheck in the Plan Year. These deductions appear as a credit to your Health FSA. As you incur eligible expenses, you will submit a claim form (through mail, fax or on-line) in order to be reimbursed from your account, or use your Flex Card at point of service. Health FSA claims are paid out up to the full annual election amount plus any Rollover amount that you may have from the previous year (see subsection entitled “Rollover Amount” below), less what has already been paid out to you.

**ELIGIBLE EXPENSES**

Eligible claims must be incurred during the Plan Year (January 1 through December 31). According to Internal Revenue Service (“IRS”) rules, an expense is considered incurred when the service is actually received, not when you are billed or pay for the service. In general, the expenses that are reimbursable are those that would be considered deductible as medical expenses under Section 213 of the IRS Code if you were paying for them with after-tax dollars. Covered expenses include, but are not limited to: hospital bills, doctor bills, dental bills, prescription drugs, dental care, vision care, nursing care, certain transportation expenses related to illness, support or corrective devices, and eyeglasses and contact lenses. Reimbursements for “medicines and drugs” are permissible under IRS regulations. “Medicines and drugs” includes only items that are legally procured and generally accepted as falling into the category of medicines and drugs.

Over-the-counter (“OTC”) medicines and drugs are not reimbursable under the Plan, unless the OTC medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or insulin.

For a sample list of eligible health care expenses, please go to: www.myCafeteriaPlan.com/employee/eligible-expenses/

**INELIGIBLE EXPENSES**

Examples of expenses specifically disallowed from the Health FSA by the IRS include: payments for services that are not medical in nature, cosmetic surgery that does not meaningfully promote the proper function of the body or prevent or treat an illness or disease, teeth bleaching, and health club membership fees. Toiletries, cosmetics and sundries are not “medicines and drugs” and amounts expended for these items are not expenditures for “medical care.”

You **may not** receive Health FSA reimbursement for a health care expense if you also itemize the expense as a deduction on your income tax return.

You **may not** receive Health FSA reimbursement for an over-the-counter (“OTC”) medicine or drug unless the OTC medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or insulin.

You **may not** use the Health FSA to pay for premiums on other coverage you may have, payments for coverage extending beyond the end of the Plan Year, or for the expenses of a product which is advertised, marketed or offered as long-term care insurance, even if those expenses would be deductible under Section 213 of the Code. Further, only medical expenses incurred during a period
of coverage and not reimbursable through other plans are eligible for reimbursement under the Health FSA.

BENEFIT ELECTIONS

Once made, your election amount is generally irrevocable: you can only change your election during the Plan Year as a result of an eligible change in family status, such as marriage, divorce, birth/adoption, termination of employment, etc. (See Section 4.4 for further information.) No change in your election will be permitted unless there is at least one payroll period remaining in the Plan Year.

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<tr>
<th>Annual Amount You May Contribute (2017)</th>
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<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Flexible Spending Account</td>
<td>$130</td>
<td>$2,600</td>
</tr>
</tbody>
</table>

The Health FSA maximum annual amount described above applies on an individual basis and is not a combined family limit (e.g., if a husband and wife are each employed by the Employer, each individual may separately elect to contribute up to the maximum contribution amount).

The maximum dollar amount described above will be increased annually to the maximum extent permissible under Internal Revenue Code Section 125(i). The allowable annual maximum Health FSA contribution will be communicated to you at open enrollment.

Eligible Employees who terminate employment and are rehired within the same year may make a new election, unless they are rehired within 30 days, in which case their previous election will be reinstated.

Please be advised that your election of Salary Reduction Contributions for the FSA is only effective for the Plan Year for which it is made. Therefore, you must be sure to make a new election for each Plan Year for which you wish to claim reimbursements under the FSA.

ROLLOVER AMOUNTS

At the end of the plan year’s run-out period, after all eligible reimbursements have been made, any unused funds in the Health FSA, up to $500, will rollover into the new plan year; any unused funds in the Health FSA account over $500 will be forfeited. The rollover amount does not count against or otherwise affect the maximum contribution amount for the new plan year.

In order to prevent the loss of funds, it is important to plan carefully so that your annual election matches your actual expenses as closely as possible. Only expenses incurred during the current plan year are eligible for reimbursement from current plan year funds.

CLAIM FILING PROCEDURES

You have several options for filing claims for reimbursement from your FSA account.

1. Flex Card
You can use the Flex Card to pay for your eligible expenses at the point of sale. Make sure to keep all documentation for your records as MyCafeteriaPlan will request you send in the documentation if the transactions isn’t able to be automatically approved. A transaction can be automatically approved if the amount matches a copay from your employer’s group health plan or if the Flex Card is used for prescriptions purchased at an Inventory Information Approval System (IIAS) merchant.

2. MyCafeteriaPlan On-the-Go Mobile App

3. Online at myCafeteriaPlan.com

4. Manual Claim Form
   Fax to 937.865.6502
   Mail to 432 East Pearl St., Miamisburg, OH 45342

**DIRECT DEPOSIT**

If you wish to receive reimbursements from your Health FSA via direct deposit click on the following link MyCafeteriaPlanDirectDeposit.pdf to download a paper Direct Deposit authorization form, or follow the steps below to make your election on-line.

1. Login to your account at www.myCafeteriaPlan.com
2. Click on the Profile Tab and select Bank Account
3. Enter your bank account information and submit

**REIMBURSEMENT SCHEDULE**

Claims that have been processed are paid weekly on Fridays, except for holidays. Claims must be received by noon Thursday in order to be processed on Friday.

**CHANGE IN FAMILY STATUS**

You may change your FSA election during the Plan Year only if you experience a qualifying change in status, and if that change in status is consistent with the desired change in election. See Article IV of this SPD for details, or contact Human Resources.

Generally the effective date of an allowed change will be the first of the month following the change except that changes for the birth/adoptions of a child can be effective the date of the birth/adoptions. You must complete a change of election form in order to make any mid-year change.

**CLAIMS RUNOUT PERIOD AND FORFEITURES**

You have until March 31 following the end of the Plan Year to file claims for services incurred in the current Plan Year (your claims must be faxed or post-marked by March 31). After this deadline, any unused funds up to $500 in your Health FSA account will rollover into the new plan
year. The rollover amount does not count against or otherwise affect the maximum contribution amount for the new plan year. Any unused funds in the Health FSA account over $500 will be forfeited, therefore, it is important to plan carefully. Remember, even if you do forfeit some money at the end of the Plan Year, you may still have realized a net tax savings for the year. See Article IV for further information.

TERMINATION OF EMPLOYMENT AND FSA BENEFITS

If you terminate employment, you will no longer be an active Participant in the FSA (your period of coverage will end). Typically your pre-tax contribution will continue through your final paycheck. You will be able to submit claims incurred during your period of coverage until the end of the claims runout period (91 days after the end of the plan year).

Upon termination of employment you may also be eligible for certain COBRA rights, which would require you to continue contributions to the plan for the remainder of the Plan Year but will allow you to submit claims incurred through the end of the Plan Year. See the COBRA section of this SPD (Article V), or contact Human Resources for further information.

AFFECT OF FSA PARTICIPATION ON TAXES

If you participate in the FSA, your savings will depend on how much you contribute and on your tax bracket. The following example illustrates possible savings for an employee participating in both a Health and Dependent Care FSA:

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Adjusted Monthly Salary</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Before-Tax Medical Cost</td>
<td>$0</td>
<td>-$100</td>
</tr>
<tr>
<td>Before-tax Dependent Daycare Cost</td>
<td>$0</td>
<td>-$300</td>
</tr>
<tr>
<td>Taxable Salary</td>
<td>$3,000</td>
<td>$2,600</td>
</tr>
<tr>
<td>Taxes – Federal &amp; Social Security (25%)</td>
<td>-$750</td>
<td>-$650</td>
</tr>
<tr>
<td>After-Tax Medical Cost</td>
<td>-$100</td>
<td>$0</td>
</tr>
<tr>
<td>After-Tax Dependent Daycare costs</td>
<td>-$300</td>
<td>$0</td>
</tr>
<tr>
<td>Net Monthly Salary</td>
<td>$1,850</td>
<td>$1,950</td>
</tr>
<tr>
<td>Monthly Savings</td>
<td>$0</td>
<td>$100 Per Month</td>
</tr>
<tr>
<td>Yearly Savings</td>
<td>$0</td>
<td>$1,200 Per Year!*</td>
</tr>
</tbody>
</table>

*The amount you save in taxes with a FSA will vary depending on the amount you set aside in the account, your annual earnings, whether or not you pay Social Security taxes, the number of exemptions and deductions you claim on your tax return, your tax bracket and your state and local tax regulations.
If you participate in the Health FSA and have already been reimbursed through the Health FSA, you cannot also claim the expenses on your tax return. Check with your tax advisor for information on how participation will affect your tax savings.

**SOCIAL SECURITY IMPACT**

FSA participation may affect your future Social Security retirement benefits. This will happen if your taxable income is below the Social Security taxable wage base. For most employees, however, the immediate tax savings using the FSA outweigh any possible reduction in future Social Security benefits. Again, consult your own tax advisor for specific advice.

**W-2 REPORTING**

The earnings reported on the W-2 form you receive after year end will **NOT** include the contributions you made to your FSA. These contributions are not part of your taxable income, therefore your taxes will be lower than if you had not participated in the program.

**CONTACTING MYCAFETERIAPLAN**

There are several convenient ways to access your account and/or contact MyCafeteriaPlan.

**Web Portal**

Enrolled Participants have 24/7 direct access to the MyCafeteriaPlan web portal, where you can easily check your balances and manage your account, view important alerts about deadlines, and file claims.

To login to your account go to www.mycafeteriaplan.com and click the “Account Login” button to begin. When logging on for the first time, your login information will be as follows:

- **User Name:** First initial of your first name, last name, last 4 digits of your Social Security Number, for example - Tsmith1234 (not case sensitive).
- **Password:** Last 4 digits of your Social Security Number, for example - 1234

Once you’ve logged in to your account, you’ll be asked to change your login information and answer a few short security questions to ensure the ongoing safety of your account. You will see a list of questions, but you only need to answer five.

**Mobile App**

Mobile device users can download the free MyCafeteriaPlan app for iPhone and iPod Touch and Android mobile devices. The apps allow access to your Flexible Spending Account anytime, anywhere. You can easily check your balances and manage your account, view important alerts about deadlines, and file claims.

Signing up is simple:
Step 1: Use your device’s app store to install the app
Step 2: Login with your standard username and password*
Step 3: Access your account anywhere

*First time login – participants can access their account for the first time directly from the mobile app. The default username and password can be used, the new password can be selected and security questions answered. See Web Portal section above for default username and password information.

Customer Service by Phone or Email
Representatives from the MyCafeteriaPlan Customer Service Department are available to help you with your account Monday through Friday 8am – 8pm EST.

Phone:  (800) 865-6543
Email:  Customer_Service@myCafeteriaPlan.com
APPENDIX F

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

INTRODUCTION

Middlebury sponsors the Dependent Care Flexible Spending Account (“Dependent Care FSA”), which allows you to set aside money, on a pre-tax basis, for non-reimbursed dependent daycare expenses for one or more of your “qualifying dependents”. As you incur dependent daycare expenses throughout the year, you can get reimbursed with tax-free dollars from your spending account. With an FSA, every dollar you set aside saves you taxes and increases your spendable income. You elect to have your annual contribution deducted from your paycheck each pay period, in equal installments throughout the year – before federal income, state income (in most cases) and Social Security taxes are taken out. Using these accounts can be a valuable tool for budgeting and saving money on taxes.

PLAN ADMINISTRATION

Effective January 1, 2017 Middlebury’s Dependent Care FSA is administered by Business Plans, Inc. (BPI), through their “MyCafeteriaPlan” FSA service.

PLAN ENROLLMENT

Unless otherwise noted, coverage becomes effective the first of the month after (or coincident with) the employee and/or dependents entering eligible status.

Eligible Employees, as defined in Section 2.1, are allowed to participate in the FSA. Enrolled Eligible Employees may use this Dependent Care FSA to cover dependent daycare expenses incurred for qualifying dependents. (See Article II for full information on eligibility.)

You must enroll for coverage within thirty (30) days of your eligibility date; otherwise you must wait until the next annual Open Enrollment Period to enroll. There will be an annual Open Enrollment Period prior to the beginning of each Plan Year. The effective date of coverage will be January 1 of the following year.

DEPENDENT CARE PLAN DETAILS

Dependent care expenses incurred for the care of one or more of your qualifying dependents, which are necessary in order for you and your Spouse (if any), to be able to work are eligible for reimbursement through the Dependent Care FSA. Only children under the age of thirteen or adults or children over the age of thirteen who are incapable of self-care are considered eligible dependents under this plan. In addition, the dependent must reside with you for the majority of the year in order to be eligible.
Childcare services will qualify for reimbursement from the Dependent Care FSA if they meet these requirements:

- The child must be under 13 years old and must be your Dependent under federal tax rules. **Note:** If your child turns 13 during the year, you cannot stop your contribution at that time, so plan accordingly. However, you may be reimbursed for eligible expenses incurred prior to the child’s 13th birthday.
- If the services are provided by a day-care facility that cares for six or more children at the same time, it must be a qualified day-care provider.
- The services must be incurred to enable you, or you and your Spouse (if you are married), to be employed or for you to be employed and your Spouse to be a full-time student.
- The amount reimbursed must not be greater than your income, or combined income of you as an Eligible Employee and your Spouse, whichever is less.
- Services must be for the physical care of the child, not for education, meals, etc.

In order to exclude reimbursements for dependent care expenses from your taxable income, you generally must provide the name, address and taxpayer identification number of all your dependent care providers on your federal income tax return.

If you elect to participate in the Dependent Care FSA, your Employer will establish a Dependent Care Flexible Spending Account on your behalf. The amount you elect to contribute for the Plan Year will be pro-rated and deducted on a pre-tax basis (before federal, state, and FICA taxes) from each paycheck in the Plan Year. These deductions appear as a credit to your Dependent Care FSA. As you incur eligible expenses, you will submit a claim in order to be reimbursed from your account, or use your Flex Card at point of service. Dependent Care FSA claims are paid out **only up to the amount contributed at the time of the request for reimbursement**, less what has already been paid out to you.

**ELIGIBLE EXPENSES**

Eligible claims must be incurred during the Plan Year (January 1 through December 31). According to Internal Revenue Service (“IRS”) rules, an expense is considered incurred when the service is actually received, not when you are billed or pay for the service.

In general, allowable dependent daycare expenses include payment to the following when the expenses enable you to work:

- baby-sitters and childcare centers;
- family day care providers;
- after school programs;
- nursery schools;
- day camps;
- caregivers for a disabled Dependent or Spouse who lives with you; and
- household services, provided that a portion of these expenses are for a qualifying dependent incurred to ensure the qualifying dependent’s well-being and maintenance.
INELIGIBLE EXPENSES

Examples of expenses specifically disallowed from the Dependent Care FSA include:

- dependent care expenses that are provided to one of your Dependents by a family member, unless the family member is age 19 or older by the end of the year and will not be claimed as a Dependent on your federal tax return;
- expenses for food and clothing;
- education expenses once the child begins attending kindergarten;
- health care expenses for your Dependents;
- overnight camps; and
- expenses payable through any other insurance plan, or that actually have been paid under another dependent care assistance plan within the meaning of IRS Code Section 129.

BENEFIT ELECTIONS

Once made, your election amount is generally irrevocable: you can only change your election during the Plan Year as a result of an eligible change in family status, such as marriage, divorce, birth/adoption, termination of employment, etc. (See Section 4.4 for further information.) No change in your election will be permitted unless there is at least one payroll period remaining in the Plan Year.

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<th>Annual Amount You May Contribute (2017)</th>
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<tr>
<td>Dependent Care Flexible Spending Account</td>
<td>$130</td>
<td>$5,000*</td>
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</table>

*Your limit for a Dependent Care FSA is determined by your tax filing status and is either: $2,500 for Married filing separately or $5,000 for Single Head of Household or Married filing jointly. If your spouse is a participant in the same or another cafeteria plan, the total of your combined Dependent Care FSA elections cannot exceed $5,000.

Eligible Employees who terminate employment and are rehired within the same year may make a new election, unless they are rehired within 30 days, in which case their previous election will be reinstated.

Please be advised that your election of Salary Reduction Contributions for the FSA is only effective for the Plan Year for which it is made. Therefore, you must be sure to make a new election for each Plan Year for which you wish to claim reimbursements under the FSA.

CLAIM FILING PROCEDURES

You have several options for filing claims for reimbursement from your FSA account.

1. Flex Card
You can use the Flex Card to pay for your eligible plan expenses at the point of sale. Make sure to keep all documentation for your records as MyCafeteriaPlan will request you send in the documentation.

2. MyCafeteriaPlan On-the-Go Mobile App

3. Online at myCafeteriaPlan.com

4. Manual Claim Form
   
   Fax to 937.865.6502
   Mail to 432 East Pearl St., Miamisburg, OH 45342

**DIRECT DEPOSIT**

If you wish to receive reimbursements from your Dependent Care FSA via direct deposit click on the following link  MyCafeteriaPlanDirectDeposit.pdf to download a paper Direct Deposit authorization form, or follow the steps below to make your election on-line.

1. Login to your account at www.myCafeteriaPlan.com
2. Click on the Profile Tab and select Bank Account
3. Enter your bank account information and submit

**REIMBURSEMENT SCHEDULE**

Claims that have been processed are paid weekly on Fridays, except for holidays. Claims must be received by noon Thursday in order to be processed on Friday.

**CHANGE IN FAMILY STATUS**

You may change your FSA election during the Plan Year only if you experience a qualifying change in status, and if that change in status is consistent with the desired change in election. See Article IV of this SPD for details, or contact Human Resources.

Generally the effective date of an allowed change will be the first of the month following the change except that changes for the birth/adoption of a child can be effective the date of the birth/adoption. You must complete a change of election form in order to make any mid-year change.

**CLAIMS RUNOUT PERIOD AND FORFEITURES**

You have until March 31 following the end of the Plan Year to file claims for services incurred in the current Plan Year (your claims must be faxed or post-marked by March 31). After this deadline, any unused funds in your Dependent Care account will be forfeited, therefore, it is important to plan carefully. However, remember, even if you do forfeit some money at the end of the Plan Year, you may still have realized a net tax savings for the year. See Article IV for further information.
TERMINATION OF EMPLOYMENT AND FSA BENEFITS

If you terminate employment, you will no longer be an active Participant in the FSA (your period of coverage will end). Typically your pre-tax contribution will continue through your final paycheck. You will be able to submit claims incurred during your period of coverage until the end of the claims runout period (91 days after the end of the plan year).

AFFECT OF FSA PARTICIPATION ON TAXES

If you participate in the FSA, your savings will depend on how much you contribute and on your tax bracket. The following example illustrates possible savings for an employee participating in both a Health and Dependent Care FSA:

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*The amount you save in taxes with a FSA will vary depending on the amount you set aside in the account, your annual earnings, whether or not you pay Social Security taxes, the number of exemptions and deductions you claim on your tax return, your tax bracket and your state and local tax regulations.

Before electing to participate in the Dependent Care FSA, you should consider (with your tax advisor if necessary) whether you will benefit more by using the Dependent Care FSA or the tax credit (or a combination). IRS Publication 503 may also be helpful in making this determination.

SOCIAL SECURITY IMPACT

FSA participation may affect your future Social Security retirement benefits. This will happen if your taxable income is below the Social Security taxable wage base. For most employees, however, the immediate tax savings using the FSA outweigh any possible reduction in future Social Security benefits. Again, consult your own tax advisor for specific advice.
W-2 REPORTING

The earnings reported on the W-2 form you receive after year end will NOT include the contributions you made to your FSA. These contributions are not part of your taxable income, therefore your taxes will be lower than if you had not participated in the program. However, your Dependent Care FSA contributions will be reported in a separate W-2 box so that, if applicable, your contribution can be coordinated with the federal child care tax credit.

CONTACTING MYCAFETERIAPLAN

There are several convenient ways to access your account and/or contact MyCafeteriaPlan.

Web Portal
Enrolled Participants have 24/7 direct access to the MyCafeteriaPlan web portal, where you can easily check your balances and manage your account, view important alerts about deadlines, and file claims.

To login to your account go to www.mycafeteriaplan.com and click the “Account Login” button to begin. When logging on for the first time, your login information will be as follows:

  **User Name:** First initial of your first name, last name, last 4 digits of your Social Security Number, for example - Tsmith1234 (not case sensitive).
  **Password:** Last 4 digits of your Social Security Number, for example - 1234

Once you’ve logged in to your account, you’ll be asked to change your login information and answer a few short security questions to ensure the ongoing safety of your account. You will see a list of questions, but you only need to answer five.

Mobile App
Mobile device users can download the free MyCafeteriaPlan app for iPhone and iPod Touch and Android mobile devices. The apps allow access to your Flexible Spending Account anytime, anywhere. You can easily check your balances and manage your account, view important alerts about deadlines, and file claims.

Signing up is simple:

  Step 1: Use your device’s app store to install the app
  Step 2: Login with your standard username and password*
  Step 3: Access your account anywhere

*First time login – participants can access their account for the first time directly from the mobile app. The default username and password can be used, the new password can be selected and security questions answered. See Web Portal section above for default username and password information.
Customer Service by Phone or Email
Representatives from the MyCafeteriaPlan Customer Service Department are available to help you with your account Monday through Friday 8am – 8pm EST.

Phone: (800) 865-6543
Email: Customer_Service@myCafeteriaPlan.com
POLICYHOLDER: The President and Fellows of Middlebury College

POLICY NUMBER: 469869 001

POLICY EFFECTIVE DATE: October 1, 2015

POLICY ANNIVERSARY DATE: January 1

GOVERNING JURISDICTION: Vermont

Unum Life Insurance Company of America (referred to as Unum) will provide benefits under this policy. Unum makes this promise subject to all of this policy's provisions.

The policyholder should read this policy carefully and contact Unum promptly with any questions. This policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. This policy consists of:

- all policy provisions and any amendments and/or attachments issued;
- employees' signed applications; and
- the certificate of coverage.

This policy may be changed in whole or in part. Only an officer or a registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for Unum at Portland, Maine on the Policy Effective Date.

President

Secretary

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
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BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN

EFFECTIVE DATE: October 1, 2015

POLICY NUMBER: 469869 001

ELIGIBLE GROUP(S):

All Full-Time Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Staff Employees
Employees who are working at least 1000 hours or more per year.

Faculty Employees
Employees who are actively working for the policyholder teaching .5 FTE's (full time equivalents) or more per year.

Faculty Employees who are appointed to an Administrative Assignment
Employees who are actively working for the policyholder at least .5 FTE's (full-time equivalents) or more per year.

WAITING PERIOD:

For employees in an eligible group on or before October 1, 2015: None

For employees entering an eligible group after October 1, 2015: First of the month coincident with or next following the date you enter an eligible group

REHIRE:

If your employment ends and you are rehired within 90 days, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

Premium Waiver: 180 days

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

1.5 x annual earnings

All amounts are rounded to the next higher multiple of $1,000, if not already an exact multiple thereof.
AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

If you have reached age 70, but not age 75, your amount of life insurance will be:
- 65% of the amount of life insurance you had prior to age 70; or
- 65% of the amount of life insurance shown above if you become insured on or after age 70 but before age 75.

There will be no further increases in your amount of life insurance.

If you have reached age 75 or more, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to your first reduction; or
- 50% of the amount of life insurance shown above if you become insured on or after age 75.

There will be no further increases in your amount of life insurance.

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

$600,000

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit
Conversion
Continuity of Coverage
Portability

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.
BENEFITS AT A GLANCE

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss. The amount you or your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death or any other covered loss according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN

EFFECTIVE DATE: October 1, 2015

POLICY NUMBER: 469869 001

ELIGIBLE GROUP(S):

   All Full-Time Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

   Staff Employees
   Employees who are working at least 1000 hours or more per year.

   Faculty Employees
   Employees who are actively working for the policyholder teaching .5 FTE’s (full time equivalents) or more per year.

   Faculty Employees who are appointed to an Administrative Assignment
   Employees who are actively working for the policyholder at least .5 FTE’s (full-time equivalents) or more per year.

WAITING PERIOD:

   For employees in an eligible group on or before October 1, 2015: None

   For employees entering an eligible group after October 1, 2015: First of the month coincident with or next following the date you enter an eligible group

REHIRE:

   If your employment ends and you are rehired within 90 days, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

   Your Employer pays the cost of your coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

   AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU (FULL AMOUNT)
   1.5 x annual earnings

   All amounts are rounded to the next higher multiple of $1,000, if not already an exact multiple thereof.

   AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

   If you have reached age 70, but not age 75, your amount of AD&D insurance will be:
   - 65% of the amount of AD&D insurance you had prior to age 70; or
   - 65% of the amount of AD&D insurance shown above if you become insured on or after age 70 but before age 75.
There will be no further increases in your amount of AD&D insurance.

If you have reached age 75 or more, your amount of AD&D insurance will be:
- 50% of the amount of AD&D insurance you had prior to your first reduction; or
- 50% of the amount of AD&D insurance shown above if you become insured on or after age 75.

There will be no further increases in your amount of AD&D insurance.

MAXIMUM BENEFIT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE FOR YOU:

$600,000

REPATRIATION BENEFIT FOR YOU

Maximum Benefit Amount:
Up to $5,000

The Repatriation Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your accidental death benefit must be paid first.

SEATBELT(S) AND AIR BAG BENEFIT FOR YOU

Benefit Amount:

Seatbelt(s): 10% of the Full Amount of your accidental death and dismemberment insurance benefit.

Air Bag: 5% of the Full Amount of your accidental death and dismemberment insurance benefit.

Maximum Benefit Payment:

Seatbelt(s): $25,000

Air bag: $5,000

The Seatbelt(s) and Air Bag Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Seatbelt(s) and Air Bag Benefit, your accidental death benefit must be paid first.

EDUCATION BENEFIT

Each Qualified Child

Benefit Amount per Academic Year for which a Qualified Child is enrolled:
6% of the Full Amount of the employee’s accidental death and dismemberment insurance to a maximum of $6,000.

Maximum Benefit Payments:
4 per lifetime

Maximum Benefit Amount:

$24,000

Maximum Benefit Period:
6 years from the date the first benefit payment has been made.
The Education Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Education Benefit, your accidental death benefit must be paid first.

**EXPOSURE AND DISAPPEARANCE BENEFIT FOR YOU**

Maximum Benefit Amount: The Full Amount

**SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.**

**OTHER FEATURES:**

Portability

Continuity of Coverage is available under this plan - refer to the ACCIDENTAL DEATH AND DISMEMBERMENT OTHER BENEFIT FEATURES for further details.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.
CLAIM INFORMATION
LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on your disability, written notice and proof of claim must be sent no later than 90 days after the end of the elimination period.

If a claim is based on death, written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

If you have a disability, you must notify us immediately when you return to work in any capacity, regardless of whether you are working for your Employer.

HOW DO YOU FILE A CLAIM FOR A DISABILITY?

You or your authorized representative, and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

If your claim is based on your disability, your proof of claim, provided at your expense, must show:

- that you are under the regular care of a physician;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation; and
- the name and address of any hospital or institution where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.
If claim is based on death, proof of claim, provided at your or your authorized representative’s expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim or proof of continuing disability. Unum will deny your claim if the appropriate information is not submitted.

**WHEN CAN UNUM REQUEST AN AUTOPSY?**

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

**HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)**

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum’s legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.
**HOW WILL UNUM MAKE PAYMENTS?**

If your life claim is at least $10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to your beneficiary.

Also, your beneficiary may request the life claim to be paid according to one of Unum’s other settlement options. This request must be in writing in order to be paid under Unum’s other settlement options.

**WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?**

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

**WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)**

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an “assignee”); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s)’ provisions before receiving and registering an assignment.
CLAIM INFORMATION

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on death or other covered loss, written notice and proof of claim must be sent no later than 90 days after the date of death or the date of any other covered loss.

If a claim is based on the Education Benefit, written notice and proof of claim must be sent no later than 60 days after the date of your death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the time proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

HOW DO YOU FILE A CLAIM FOR A COVERED LOSS?

You or your authorized representative and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF CLAIM?

If claim is based on death or other covered loss, proof of claim for death or covered loss, provided at your or your authorized representative's expense, must show:

- the cause of death or covered loss;
- the extent of the covered loss;
- the date of covered loss; and
- the name and address of any hospital or institution where treatment was received, including all attending physicians.

Also, in case of death, a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim. Unum will deny your claim if the appropriate information is not submitted.

If a claim is based on the Education Benefit, proof of claim, provided at your authorized representative’s expense, must show:
- the date of enrollment of your qualified child in an accredited post-secondary institution of higher learning;
- the name of the institution;
- a list of courses for the current academic term; and
- the number of credit hours for the current academic term.

**WHEN CAN UNUM REQUEST AN AUTOPSY?**

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

**HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)**

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your accidental death and dismemberment insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

**HOW WILL UNUM MAKE PAYMENTS?**

If your accidental death or dismemberment claim is at least $10,000 Unum will make available to you or your beneficiary a **retained asset account** (the Unum Security Account).
Payment for the accidental death or dismemberment claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the accidental death or dismemberment claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, your beneficiary may request the accidental death claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

The Education Benefit will be paid to your qualified child or the qualified child's legal representative.

All other benefits will be paid to you.

**WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?**

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

**WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS?**

(Assignability Rights)

The rights provided to you by the plan(s) for accidental death insurance benefits are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.
POLICYHOLDER PROVISIONS

WHAT IS THE COST OF THIS INSURANCE?

LIFE INSURANCE

Premium payments are required for an insured while he or she is disabled under this plan.

The initial premium for each plan is based on the initial rate(s) shown in the Rate Information Amendment(s).

PREMIUM WAIVER

Unum does not require premium payments for an insured employee’s life coverage if he or she is under age 60 and disabled for 180 days. Proof of disability, provided at the insured employee's expense, must be filed by the insured employee and approved by Unum.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

The initial premium for each plan is based on the initial rate(s) shown in the Rate Information Amendment(s).

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

WHEN IS PREMIUM DUE FOR THIS POLICY?

Premium Due Dates: Premium due dates are based on the Premium Due Dates shown in the Rate Information Amendment(s).

The Policyholder must send all premiums to Unum on or before their respective due date. The premium must be paid in United States dollars.

WHEN ARE INCREASES OR DECREASES IN PREMIUM DUE?

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Unum will only adjust premium for the current policy year and the prior policy year. In the case of fraud, premium adjustments will be made for all policy years.
WHAT INFORMATION DOES UNUM REQUIRE FROM THE POLICYHOLDER?

The Policyholder must provide Unum with the following on a regular basis:

- information about employees:
  - who are eligible to become insured;
  - whose amounts of coverage change; and/or
  - whose coverage ends;
- occupational information and any other information that may be required to manage a claim; and
- any other information that may be reasonably required.

Policyholder records that, in Unum's opinion, have a bearing on this policy will be available for review by Unum at any reasonable time.

Clerical error or omission by Unum will not:

- prevent an employee from receiving coverage;
- affect the amount of an insured's coverage; or
- cause an employee's coverage to begin or continue when the coverage would not otherwise be effective.

WHO CAN CANCEL OR MODIFY THIS POLICY OR A PLAN UNDER THIS POLICY?

This policy or a plan under this policy can be cancelled:

- by Unum; or
- by the Policyholder.

Unum may cancel or modify this policy or a plan if:

- there is less than 100% participation of those eligible employees for a Policyholder paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a plan; or
- the Policyholder does not promptly provide Unum with information that is reasonably required; or
- the Policyholder fails to perform any of its obligations that relate to this policy; or
- fewer than 10 employees are insured under a plan; or
- the premium is not paid in accordance with the provisions of this policy that specify whether the Policyholder, the employee, or both, pay the premiums; or
- the Policyholder does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Policyholder and/or its employees; or
- the Policyholder fails to pay any premium within the 31 day grace period.

If Unum cancels or modifies this policy or a plan, for reasons other than the Policyholder's failure to pay premium, a written notice will be delivered to the Policyholder at least 31 days prior to the cancellation date or modification date. The Policyholder may cancel this policy or plan if the modifications are unacceptable.
If any portion of the premium is not paid during the grace period, Unum will either cancel or modify this policy or a plan automatically at the end of the grace period. The Policyholder is liable for premium for coverage during the grace period. The Policyholder must pay Unum all premium due for the full period each plan is in force.

The Policyholder may cancel this policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Policyholder and Unum agree, this policy or a plan can be cancelled on a earlier date. If Unum or the Policyholder cancels this policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If this policy or a plan is cancelled, the cancellation will not affect a payable claim.

**WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE UNDER THIS POLICY WHILE HE OR SHE IS ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?**

We will continue the employee's coverage in accordance with the Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and the Employer approved the employee's leave in writing.

Coverage will be continued until the end of the latest of:

- the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law; or
- the leave period provided to the employee for injury or sickness.

If the Employer's Human Resource policy doesn't provide for continuation of a plan for an employee during a family and medical leave of absence, the employee's coverage will be reinstated when he or she returns to active employment.

We will not:

- apply a new waiting period; or
- require evidence of insurability.

**DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:**

**FOR LIFE INSURANCE:**

NAME/LOCATION (CITY AND STATE)

The Middlebury Institute of International Studies at Monterey
Middlebury, Vermont

**FOR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE:**

NAME/LOCATION (CITY AND STATE)

The Middlebury Institute of International Studies at Monterey
Middlebury, Vermont
CERTIFICATE SECTION

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the Policyholder), the policy will govern. The policy may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the policy. Any other person, including an agent, may not change the policy or waive any part of it.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder’s address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
IMPORTANT INFORMATION REGARDING THE ACCELERATED BENEFIT

The insurance evidenced by this certificate provides life insurance, with the accelerated benefit option (An accelerated payment of your death benefit).

- This accelerated benefit product is NOT a long-term care policy.

- Accelerated benefits paid under the policy may be taxable and assistance should be sought from a personal tax advisor.

- The receipt of the accelerated benefit may affect your eligibility for government programs.

- Your amount of life insurance will be reduced by the accelerated benefit payment.

- If you qualify for premium waiver, your life insurance will be continued without further premium payments according to the terms of the policy.
GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your waiting period.

WHEN DOES YOUR COVERAGE BEGIN?

When your Employer pays 100% of the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the later of:

- the date you are eligible for coverage; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

When you and your Employer share the cost of your coverage under a plan or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you apply for insurance on or before that date;
- the date you apply for insurance, if you apply within 31 days after your eligibility date; or
- the date Unum approves your evidence of insurability form, if evidence of insurability is required.

Evidence of insurability is required if you:

- are a late applicant, which means you apply for coverage more than 31 days after the date you are eligible for coverage; or
- voluntarily cancelled your coverage and are reapplying.

An evidence of insurability form can be obtained from your Employer.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.
ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE NOT WORKING DUE TO INJURY OR SICKNESS?

If you are not working due to injury or sickness, and if premium is paid, you may continue to be covered up to your retirement date.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary layoff, and if premium is paid, you will be covered through the end of the month that immediately follows 60 days from the date your temporary layoff begins.

If you are on a parental leave of absence, and if premium is paid, you will be covered in accordance with your Employer's policy on leaves of absence.

If you are on any other leave of absence, and if premium is paid, you will be covered for up to 12 months following the date your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage due to a change in your annual earnings or due to a plan change requested by your Employer will take effect immediately or on the date Unum approves your evidence of insurability form, if evidence of insurability is required. You must be in active employment or on a covered layoff or leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional coverage due to a change in your annual earnings or due to a plan change will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the Policy or a plan ends on the earliest of:

- the date the Policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Unum will provide coverage for a payable claim which occurs while you are covered under the Policy or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.
HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage or an evidence of insurability form a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application or an evidence of insurability form as a basis for doing this.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE POLICY REPLACE OR AFFECT ANY WORKERS’ COMPENSATION OR STATE DISABILITY INSURANCE?

The policy does not replace or affect the requirements for coverage by any workers’ compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM’S AGENT?

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.
LIFE INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

WHAT ARE YOUR ANNUAL EARNINGS?

Annual Contract and Salaried Employees
"Annual Earnings" means your annual contract salary in effect just prior to your date of loss. Annual salary is your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

Hourly Employees
"Annual Earnings" means your gross annual income from your Employer in effect just prior to your date of loss. It is figured by multiplying the current hourly rate of pay multiplied by the number of hours you are regularly scheduled to work per year, but not more than 2080 hours.

If you do not have regular work hours, "Annual Earnings" will be the lesser of:

a. the 12 calendar month period of your employment with your Employer just prior to the date of loss; or

b. the period of actual employment with your Employer.

Average hours will not be more than 2080 hours per year.

It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

Employees Participating in the Employer's Phased Retirement Policy
"Annual Earnings" is gross annual income from your Employer in effect just prior to the date you enter the Phased Retirement Agreement with your Employer. It includes your total income before taxes. It is prior to any deductions made for pre-
tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It is also prior to any elective pre-tax contributions to your Employer's Non Qualified Deferred Compensation Plan. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

**WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?**

If you become disabled while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

**WHAT HAPPENS TO YOUR LIFE INSURANCE COVERAGE IF YOU BECOME DISABLED?**

Your life insurance coverage may be continued for a specific time and your life insurance premium will be waived if you qualify as described below.

**HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO HAVE LIFE PREMIUMS WAIVED?**

You must be disabled through your elimination period.

Your elimination period is 180 days.

**WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?**

Your life insurance premium waiver will begin when we approve your claim, if the elimination period has ended and you meet the following conditions. Your Employer may continue premium payments until Unum notifies your Employer of the date your life insurance premium waiver begins.

Your life insurance premium will be waived if you meet these conditions:

- you are less than 60 and insured under the plan.
- you become disabled and remain disabled during the elimination period.
- you meet the notice and proof of claim requirements for disability while your life insurance is in effect or within three months after it ends.
- your claim is approved by Unum.

After we approve your claim, Unum does not require further premium payments for you while you remain disabled according to the terms and provisions of the plan.

Your life insurance amount will not increase while your life insurance premiums are being waived. Your life insurance amount will reduce or cease at any time it would reduce or cease if you had not been disabled.

**WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER END?**

The life insurance premium waiver will automatically end if:

- you recover and you no longer are disabled;
- you fail to give us proper proof that you remain disabled;
- you refuse to have an examination by a physician chosen by Unum;
- you reach age 65; or
- premium has been waived for 12 months and you are considered to reside outside the United States or Canada. You will be considered to reside outside the United States or Canada when you have been outside these countries for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

**HOW DOES UNUM DEFINE DISABILITY?**

You are disabled when Unum determines that:

- during the elimination period, you are not working in any occupation due to your **injury** or **sickness**; and
- after the elimination period, due to the same injury or sickness, you are unable to perform the duties of any **gainful occupation** for which you are reasonably fitted by training, education or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

**APPLYING FOR LIFE INSURANCE PREMIUM WAIVER**

Ask your Employer for a life insurance premium waiver claim form.

The form has instructions on how to complete and where to send the claim.

**WHAT INSURANCE IS AVAILABLE WHILE YOU ARE SATISFYING THE DISABILITY REQUIREMENTS? (See Conversion Privilege)**

You may use this life conversion privilege when your life insurance terminates while you are satisfying the disability requirements. Please refer to the conversion privilege below. You are not eligible to apply for this life conversion if you return to work and, again, become covered under the plan.

If an individual life insurance policy is issued to you, any benefit for your death under this plan will be paid only if the individual policy is returned for surrender to Unum. Unum will refund all premiums paid for the individual policy.

The amount of your death benefit will be paid to your named beneficiary for the plan. If, however, you named a different beneficiary for the individual policy and the policy is returned to Unum for surrender, that different beneficiary will not be paid.

If you want to name a different beneficiary for this group plan, you must change your beneficiary as described in the Beneficiary Designation page of this group plan.
WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)

When coverage ends under the plan, you can convert your coverage to an individual life policy, without evidence of insurability. The maximum amount that you can convert is the amount you are insured for under the plan. You may convert a lower amount of life insurance.

You must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- your employment terminates; or
- you no longer are eligible to participate in the coverage of the plan.

If you convert to an individual life policy, then return to work, and, again, become insured under the plan, you are not eligible to convert to an individual life policy again. However, you do not need to surrender that individual life policy when you return to work.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. You may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

WHAT LIMITED CONVERSION IS AVAILABLE IF THE POLICY OR THE PLAN IS CANCELLED? (Conversion Privilege)

You may convert a limited amount of life insurance if you have been insured under your Employer’s group plan with Unum for at least five (5) years and the Policy or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum will be the lesser of:

- $10,000; or
- your coverage amount under the plan less any amount that becomes available under any other group life plan offered by your Employer within 31 days after the date the Policy or the plan is cancelled.

PREMIUMS

Premiums for the converted insurance will be based on:

- your then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum’s customary rates in use at that time; and
- the class of risk to which you belong.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.
DEATH DURING THE THIRTY-ONE DAY CONVERSION APPLICATION PERIOD

If you die within the 31 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

EMPLOYER NOTICE

Your Employer must notify you of your conversion privilege within 15 days from the date your life insurance terminates.

If your Employer does not notify you within those 15 days, but does notify you within 60 days from the date your life insurance terminates, the time allowed for you to exercise your life conversion privilege will be extended 15 days from the date you are notified.

If your Employer does not notify you within those 60 days, the time allowed for you to exercise your life conversion privilege will expire at the end of those 60 days.

APPLYING FOR CONVERSION

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

WILL UNUM ACCELERATE YOUR DEATH BENEFIT FOR THE PLAN IF YOU BECOME TERMINALLY ILL? (Accelerated Benefit)

If you become terminally ill while you are insured by the plan, Unum will pay you a portion of your life insurance benefit one time. The payment will be based on 50% of your life insurance amount. However, the one-time benefit paid will not be greater than $750,000.

Your right to exercise this option and to receive payment is subject to the following:

- you request this election, in writing, on a form acceptable to Unum;
- you must be terminally ill at the time of payment of the Accelerated Benefit;
- your physician must certify, in writing, that you are terminally ill and your life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to Unum.

The Accelerated Benefit cannot be used by you if:

- you are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- you are required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.
Premium payments must continue to be paid on the full amount of life insurance unless you qualify to have your life premium waived.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that would be continued under a disability continuation provision or that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Policy subject to any reduction and termination provisions.

Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

**WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?**

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 24 months after your initial effective date of insurance; and
- suicide occurring within 24 months after the date any increases or additional insurance becomes effective for you.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you applied for at that time.
LIFE INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN THE POLICYHOLDER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you if you were covered by the prior policy on the day before the effective date of this policy, and if you would be eligible for coverage under this policy if you were in active employment on the effective date of this policy.

If you are on a covered layoff or leave of absence on the effective date of this policy, we will consider your layoff or leave of absence to have started on that date, and coverage for you under this provision will continue for the layoff or leave of absence period provided in this policy, or the layoff or leave of absence period remaining under the prior policy on the effective date of this policy, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this policy, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this policy, any benefits payable under this policy will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you is subject to payment of required premium and all other terms of this policy, except that the portable insurance coverage terms of this policy will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of life insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,
whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000. If the current amounts under the plan are less than $5,000, you may port the lesser amounts.

Your amount of life insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

**APPLYING FOR PORTABLE COVERAGE**

You must apply for portable coverage for yourself and pay the first premium within 31 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

You are not eligible to apply for portable coverage for yourself if:

- you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy; or
- you failed to pay the required premium under the terms of this plan.

If we determine that because of an injury or sickness, which has a material effect on life expectancy, you were not eligible for portability at the time you elected portable coverage, the benefit will be adjusted to the amount of whole life coverage the premium would have purchased under the Conversion Privilege.

**APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE**

You may increase or decrease the amount of life insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of life insurance coverage cannot be decreased below $5,000. All increases are subject to evidence of insurability. Portable coverage will reduce at the ages and amounts shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

**WHEN PORTABLE COVERAGE ENDS**

Portable coverage for you will end on the date you fail to pay any required premium.

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

**PREMIUM RATE CHANGES FOR PORTABLE COVERAGE**

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

**APPLYING FOR CONVERSION, IF PORTABLE COVERAGE ENDS OR IS NOT AVAILABLE**

If you are not eligible to apply for portable coverage or portable coverage ends, then you may qualify for conversion coverage. Refer to Conversion Privilege under this plan.

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit  
2211 Congress Street  
Portland, Maine  04122-1350  
1-800-343-5406
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT IN THE EVENT OF YOUR DEATH IF YOUR DEATH IS THE DIRECT RESULT OF AN ACCIDENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim providing you meet certain conditions.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF ACCIDENTAL DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

WHEN WILL YOU RECEIVE PAYMENT IN THE EVENT OF CERTAIN OTHER COVERED LOSSES IF THE LOSS IS THE DIRECT RESULT OF AN ACCIDENT?

You will receive payment when Unum approves the claim.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR CERTAIN OTHER COVERED LOSSES?

If Unum approves the claim, Unum will determine the payment according to the Covered Losses and Benefits List below. The benefit Unum will pay is listed opposite the corresponding covered loss.

The benefit will be paid only if an accidental bodily injury results in one or more of the covered losses listed below within 365 days from the date of the accident.

Also, the accident must occur while you are insured under the plan.

<table>
<thead>
<tr>
<th>Covered Losses</th>
<th>Benefit Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>Both Hands or Both Feet or Sight of Both Eyes</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>One Hand and Sight of One Eye</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>One Foot and Sight of One Eye</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>Speech and Hearing</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>One Hand or One Foot</td>
<td>One Half The Full Amount</td>
</tr>
<tr>
<td>Sight of One Eye</td>
<td>One Half The Full Amount</td>
</tr>
</tbody>
</table>
Speech or Hearing One Half The Full Amount
Thumb and Index Finger of Same Hand One Quarter The Full Amount

The most Unum will pay for any combination of Covered Losses from any one accident is the full amount.

The Full Amount is the amount shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE "BENEFITS AT A GLANCE" page.

WHAT ARE YOUR ANNUAL EARNINGS?

Annual Contract and Salaried Employees
"Annual Earnings" means your annual contract salary in effect just prior to your date of loss. Annual salary is your total income before taxes. It is prior any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

Hourly Employees
"Annual Earnings" means your gross annual income from your Employer in effect just prior to your date of loss. It is figured by multiplying the current hourly rate of pay multiplied by the number of hours you are regularly scheduled to work per year, but not more than 2080 hours.

If you do not have regular work hours, "Annual Earnings" will be the lesser of:

a. the calendar month period of our employment with your Employer just prior to the date of loss; or

b. the period of actual employment with your Employer

Average hours will not be more than 2080 hours per year.

It includes your total income before taxes. It is prior any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

Employees Participating in the Employer's Phased Retirement Policy
"Annual Earnings" is gross annual income from your Employer in effect just prior to the date you enter the Phased Retirement Agreement with your Employer. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It is also prior to any elective pre-tax contributions to your Employer's Non Qualified Deferred Compensation Plan. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation or income received from sources other than your Employer.
WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you have an accidental bodily injury that results in one or more of the covered losses while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT REPATRIATION BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit for the preparation and transportation of your body to a mortuary chosen by you or your authorized representative. Payment will be made if, as the result of a covered accident, you suffer loss of life at least 100 miles away from your principal place of residence.

However, when combined with two or more Unum accidental death and dismemberment insurance plans, the combined overall maximum for these plans together cannot exceed the actual expenses for the preparation and transportation of your body to a mortuary.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE “BENEFITS AT A GLANCE” page.

WHAT SEATBELT(S) AND AIR BAG BENEFIT WILL UNUM PROVIDE?

Unum will pay you or your authorized representative an additional benefit if you sustain an accidental bodily injury which causes your death while you are driving or riding in a Private Passenger Car, provided:

For Seatbelt(s):

- the Private Passenger Car is equipped with seatbelt(s); and
- the seatbelt(s) were in actual use and properly fastened at the time of the covered accident; and
- the position of the seatbelt(s) are certified in the official report of the covered accident, or by the investigating officer. A copy of the police accident report must be submitted with the claim.

Also, if such certification is not available, and it is clear that you were properly wearing seatbelt(s), then we will pay the additional seatbelt benefit.

However, if such certification is not available, and it is unclear whether you were properly wearing seatbelt(s), then we will pay a fixed benefit of $1,000.

An automatic harness seatbelt will not be considered properly fastened unless a lap belt is also used.

For Air Bag:

- the Private Passenger Car is equipped with an air bag for the seat in which you are seated; and
- the seatbelt(s) must be in actual use and properly fastened at the time of the covered accident.
No benefit will be paid if you are the driver of the Private Passenger Car and do not hold a current and valid driver's license.

No benefit will be paid if Unum is able to verify that the air bag(s) had been disengaged prior to the accident.

The accident causing your death must occur while you are insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT "BENEFITS AT A GLANCE" page.

**WHAT EDUCATION BENEFIT WILL UNUM PROVIDE FOR YOUR QUALIFIED CHILDREN?**

Unum will pay your authorized representative on behalf of each of your qualified children a lump sum payment if:

- you lose your life:
  • as a result of an accidental bodily injury; and
  • within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your accidental bodily injury occurred while you were insured under the plan;
- proof is furnished to Unum that the child is a qualified child; and
- the qualified child continues to be enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level.

The benefit amount per academic year, maximum benefit payments, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE "BENEFITS AT A GLANCE" page.

**WHEN WILL THE EDUCATION BENEFIT END FOR EACH QUALIFIED CHILD?**

The education benefit will terminate for each qualified child on the earliest of the following dates:

- the date your qualified child fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

**WHAT COVERAGE FOR EXPOSURE AND DISAPPEARANCE BENEFIT WILL UNUM PROVIDE?**

Unum will pay a benefit if you sustain an accidental bodily injury and are unavoidably exposed to the elements and suffer a loss.

We will presume you suffered loss of life due to an accident if:
- you are riding in a common public passenger carrier that is involved in an accident covered under the policy; and
- as a result of the accident, the common public passenger carrier is wrecked, sinks, is stranded, or disappears; and
- your body is not found within 1 year of the accident.

Also, the accident must occur while you are insured under the plan.
The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT "BENEFITS AT A GLANCE" page.

**WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?**

Your plan does not cover any accidental losses caused by, contributed to by, or resulting from:

- suicide, self destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while insane.
- active participation in a riot.
- an attempt to commit or commission of a crime.
- the use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your physician. This exclusion will not apply to you if the chemical substance is ethanol.
- service on full-time active duty in the Armed Forces of any country or international authority.
- travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from it while:
  - it is being used for test or experimental purposes;
  - you are operating, learning to operate or serving as a member of the crew;
  - it is being operated by or for or under the direction of any military authority.
  This exclusion does not apply to:
  - transport type aircraft operated by the Military Airlift Command of the United States; or
  - similar air transport service of any other country.
- disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.
- being intoxicated.
- war, declared or undeclared, or any act of war.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN THE POLICYHOLDER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you if you were covered by the prior policy on the day before the effective date of this policy, and if you would be eligible for coverage under this policy if you were in active employment on the effective date of this policy.

If you are on a covered layoff or leave of absence on the effective date of this policy, we will consider your layoff or leave of absence to have started on that date, and coverage for you under this provision will continue for the layoff or leave of absence period provided in this policy, or the layoff or leave of absence period remaining under the prior policy on the effective date of this policy, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this policy, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this policy, any benefits payable under this policy will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you is subject to payment of required premium and all other terms of this policy, except that the portable insurance coverage terms of this policy will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you are insured for under your Employer's group plan.

However, the amount of portable coverage for you will not be more than:

- the highest amount of accidental death and dismemberment insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000. If the current amounts under the plan are less than $5,000, you may port the lesser amounts.

Your amount of AD&D insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

**APPLYING FOR PORTABLE COVERAGE**

You must apply for portable coverage for yourself and pay the first premium within 31 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

You are not eligible to apply for portable coverage for yourself if:

- you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy; or
- you failed to pay the required premium under the terms of this plan.

**APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE**

You may increase or decrease the amount of AD&D insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of accidental death and dismemberment insurance coverage cannot be decreased below $5,000. Portable coverage will reduce at the ages and amounts shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE "BENEFITS AT A GLANCE" page.

**WHEN PORTABLE COVERAGE ENDS**

Portable coverage for you will end on the date you fail to pay any required premium.

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

**PREMIUM RATE CHANGES FOR PORTABLE COVERAGE**

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.
GLOSSARY

ACCIDENTAL BODILY INJURY means bodily harm caused solely by external, violent and accidental means and not contributed to by any other cause.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment. Temporary and seasonal workers are excluded from coverage.

ANNUAL EARNINGS means your annual income received from your Employer as defined in the plan.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to have your life premium waived by Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that within 12 months of your return to work is or can be expected to provide you with an income that is at least equal to 60% of your annual earnings in effect just prior to the date your disability began.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

HOSPITAL OR INSTITUTION means an accredited facility licensed to provide care and treatment for the condition causing your disability.

INJURY means:

- for purposes of Portability, a bodily injury that is the direct result of an accident and not related to any other cause.
- for all other purposes, a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

INSURED means any person covered under a plan.

INTOXICATED means that your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state where the accident occurred.

LAYOFF or LEAVE OF ABSENCE means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

LIFE INSURANCE BENEFIT means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.

LOSS OF A FOOT means that all of the foot is cut off at or above the ankle joint.

LOSS OF A HAND means that all four fingers are cut off at or above the knuckles joining each to the hand.

LOSS OF HEARING means the total and irrecoverable loss of hearing in both ears.

LOSS OF SIGHT means the eye is totally blind and that no sight can be restored in that eye.

LOSS OF SPEECH means the total and irrecoverable loss of speech.

LOSS OF THUMB AND INDEX FINGER means that all of the thumb and index finger are cut off at or above the joint closest to the wrist.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the policy.

POLICYHOLDER means the Employer to whom the policy is issued.
PRIVATE PASSENGER CAR means a validly registered four-wheel private passenger car (including Employer-owned cars), station wagons, jeeps, pick-up trucks, and vans that are used only as private passenger cars.

QUALIFIED CHILD is any of your unmarried dependent children under age 25 who, on the date of your death as a result of an accidental bodily injury, was either:

- enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level; or
- at the 12th grade level and enrolls as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level within 365 days following the date of your death.

Children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

RETAINED ASSET ACCOUNT:

- for Life Insurance, is an interest bearing account established through an intermediary bank in the name of your beneficiary, as owner.
- for Accidental Death and Dismemberment Insurance, is an interest bearing account established through an intermediary bank in the name of you or your beneficiary, as owner.

SICKNESS means:

- for purposes of Portability, an illness, disease or symptoms for which a person, in the exercise of ordinary prudence, would have consulted a health care provider.
- for all other purposes, an illness or disease. Disability must begin while you are covered under the plan.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.


YOU means an employee who is eligible for Unum coverage.
THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY THE STATE OF WASHINGTON. PLEASE READ CAREFULLY.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

If you had group life coverage in place with your employer through another carrier when your employer changed carriers to Unum, your prior coverage may be continued under the Unum plan to the extent the laws of your resident state require such right to continue and within the design limits of the Unum plan.

Full effect will be given to your state’s civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

For residents of Washington

The definition for ACTIVE EMPLOYMENT in the GLOSSARY section is amended to include the following:

A period of up to 6 months during which you are not working due to a strike, lockout or other labor dispute is considered active employment. Your employer may require you to pay premium during this period of time.

The WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT’S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL? (Accelerated Benefit) in the Life Insurance Benefit Information section is amended by changing the life expectancy requirement to 24 months or less, or such longer period as stated in the policy.

The WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN? provision in the Life Insurance Benefit Information section is amended to remove any exclusion for death caused by suicide.
VERMONT MANDATORY CIVIL UNIONS ENDORSEMENT

PURPOSE:

Vermont law requires that health and life insurers recognize parties to a civil union that is equivalent to coverage provided to married persons. This endorsement is part of and amends this policy, contract, certificate, summary of benefits and/or riders and endorsements to comply with Vermont law.

DEFINITIONS, TERMS, CONDITIONS AND PROVISIONS:

The definitions, terms, conditions and any other provisions of this policy, contract, certificate, summary of benefits and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family", "family member" and any other such terms include the relationship created by a civil union established according to Vermont law.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

Terms that mean or refer to family relationships arising from a marriage, such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor", "family member" and any other such terms include family relationships created by a civil union established according to Vermont law.

Where applicable, "dependent" means a spouse, a party to a civil union, and/or a child or children who are born to or brought to a marriage or to a civil union. Child or children include the insured's own natural offspring, lawfully adopted children and stepchildren. A child will be considered adopted on the date of placement in the insured's home. Child or children will also include an unmarried child who is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy or physical handicap and who become so incapable prior to the limiting age and who is dependent on the insured for support and maintenance.

They also may include foster children and other minor children who are dependent on the insured for main support and living with the insured in a regular parent-child relationship.

Where applicable, "child or covered child" includes:

- the insured's own natural offspring, lawfully adopted children and stepchildren. A child will be considered adopted on the date of placement in the insured's home.
- an unmarried child who is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy or physical handicap and who became so incapable prior to the limiting age and who is dependent on the insured for support and maintenance.
They also may include foster children and other minor children who are dependent on the insured for main support and living with the insured in a regular parent-child relationship.

**CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE**

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to life and health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as "ERISA", controls the employer/employee relationship with regard to determining eligibility for enrollment in non-exempt private employer welfare benefit plans. Because of ERISA, Vermont Act 91 relating to civil unions does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide benefits to the dependents of a party to a civil union if the public employer provides benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, summary of benefits, rider or endorsement that derive from federal law. You are advised to seek expert advise to determine your rights under this policy, contract, summary of benefits, certificate, and/or riders and endorsements.
ERISA

Additional Summary Plan Description Information

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document.

Name of Plan:
The President and Fellows of Middlebury College Plan

Name and Address of Employer:
The President and Fellows of Middlebury College
152 Maple Street
Suite 203 (Benefits)
Middlebury, Vermont
05753

Plan Identification Number:
a. Employer IRS Identification #: 03-0179298
b. Plan #: 501

Type of Welfare Plan:
Life and Accidental Death and Dismemberment

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
The President and Fellows of Middlebury College
152 Maple Street
Suite 203 (Benefits)
Middlebury, Vermont
05753
(802) 443-5000

The President and Fellows of Middlebury College is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
The President and Fellows of Middlebury College
Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**
The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number 469869 001. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

**EMPLOYER’S RIGHT TO AMEND THE PLAN**
The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

**EMPLOYER’S RIGHT TO REQUEST POLICY CHANGE**
The Employer can request a policy change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the policy.

**MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY**
The policy or a plan under the policy can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the policy or a plan if:

- there is less than 100% participation of those eligible employees for a Employer paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a plan; or
- the Employer does not promptly provide Unum with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to this policy; or
- fewer than 10 employees are insured under a plan; or
- the premium is not paid in accordance with the provisions of the policy that specify whether the Employer, the employee, or both, pay the premiums; or
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or
- the Employer fails to pay any premium within the 31 day grace period.

If Unum cancels or modifies the policy or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the policy or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the policy or a plan can be cancelled on a earlier date. If Unum or the Employer cancels the policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the policy or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

If a claim is based on death, a covered loss not based on disability or for the Education Benefit

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

If a claim is based on your disability
Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and
- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

**APPEAL PROCEDURES**

**If an appeal is based on death, a covered loss not based on disability or for the Education Benefit**

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review.
A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those policy provisions upon which the final decision is based. It will also include a statement describing your right to access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

**If an appeal is based on your disability**

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the
Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;
- a reference to the specific Plan provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;
- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, 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 summary plan description. 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.
Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 that is denied or ignored, in whole or in part, you may file suit in a state or 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, if, for example, 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, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
Unum's Commitment to Privacy

Unum understands your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

Collecting Information
We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations, and service providers.

Sharing Information
We share the types of NPI described above primarily with people who perform insurance, business, and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

Safeguarding Information
We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.
Access to Information
You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

Correction of Information
If you believe NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

Coverage Decisions
If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

Contacting Us
For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit www.unum.com/privacy or www.coloniallife.com or write to: Privacy Officer, Unum, 2211 Congress Street, C476, Portland, Maine 04122. We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.


Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

MK-1883 (2-11)
POLICYHOLDER: The President and Fellows of Middlebury College

POLICY NUMBER: 469871 001

POLICY EFFECTIVE DATE: October 1, 2015

POLICY ANNIVERSARY DATE: January 1

GOVERNING JURISDICTION: Vermont

Unum Life Insurance Company of America (referred to as Unum) will provide benefits under this policy. Unum makes this promise subject to all of this policy's provisions.

The policyholder should read this policy carefully and contact Unum promptly with any questions. This policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. This policy consists of:

- all policy provisions and any amendments and/or attachments issued;
- employees' signed applications; and
- the certificate of coverage.

This policy may be changed in whole or in part. Only an officer or a registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for Unum at Portland, Maine on the Policy Effective Date.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

President

Secretary
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BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan. You also have the opportunity to have coverage for your dependents.

EMPLOYER’S ORIGINAL PLAN

EFFECTIVE DATE: October 1, 2015

PLAN YEAR:

October 1, 2015 to January 1, 2016 and each following January 1 to January 1

POLICY NUMBER: 469871 001

ELIGIBLE GROUP(S):

All Full-Time Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Staff Employees
Employees who are working at least 1000 hours or more per year.

Faculty Employees
Employees who are actively working for the policyholder teaching .5 FTE’s (full-time equivalents) or more per year.

Faculty Employees who are appointed to an Administrative Assignment
Employees who are actively working for the policyholder at least .5 FTE’s (full-time equivalents) or more per year.

WAITING PERIOD:

For employees in an eligible group on or before October 1, 2015: None

For employees entering an eligible group after October 1, 2015: First of the month coincident with or next following the date you enter an eligible group

REHIRE:

If your employment ends and you are rehired within 90 days, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

For You:

You pay the cost of your coverage.

For Your Dependents:

You pay the cost of your dependent coverage.

ELIMINATION PERIOD:

Premium Waiver: 180 days

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.
LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

Amounts in $10,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $10,000, if not already an exact multiple thereof.

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

If you have reached age 70, but not age 75, your amount of life insurance will be:
- 65% of the amount of life insurance you had prior to age 70; or
- 65% of the amount of life insurance shown above if you become insured on or after age 70 but before age 75.

There will be no further increases in your amount of life insurance.

If you have reached age 75 or more, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to your first reduction; or
- 50% of the amount of life insurance shown above if you become insured on or after age 75.

There will be no further increases in your amount of life insurance.

EVIDENCE OF INSURABILITY IS REQUIRED FOR THE AMOUNT OF YOUR INSURANCE OVER:

$200,000

Evidence of Insurability is not required for amounts of life insurance you had in force with your Employer's prior carrier on the termination date of the prior carrier's plan.

Evidence of Insurability is required for amounts of life insurance in excess of the greater of:
- The amount(s) of life insurance you had in force with your Employer's prior carrier on the termination date of the prior carrier's plan; or
- The amount(s) of life insurance over the amount shown above.

OVERALL MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

The lesser of:
- 5 x annual earnings; or
- $500,000.

AMOUNT OF LIFE INSURANCE FOR YOUR DEPENDENTS

Spouse:

Amounts in $5,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $5,000, if not already an exact multiple thereof.

THE AMOUNT OF YOUR SPOUSE'S LIFE INSURANCE WILL REDUCE BY THE SAME PERCENTAGE AND AT THE SAME TIME YOUR LIFE INSURANCE REDUCES.

EVIDENCE OF INSURABILITY IS REQUIRED FOR THE AMOUNT OF YOUR SPOUSE'S INSURANCE OVER:

$25,000

Evidence of Insurability is not required for amounts of life insurance your spouse had in force with your Employer's prior carrier on the termination date of the prior carrier's plan.
Evidence of Insurability is required for amounts of life insurance in excess of the greater of:

- The amount(s) of life insurance your spouse had in force with your Employer's prior carrier on the termination date of the prior carrier's plan; or
- The amount(s) of life insurance over the amount shown above.

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOUR SPOUSE:

  The lesser of:
  - 100% of your amount of insurance; or
  - $500,000.

Children:

  Amounts in $1,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $1,000, if not already a multiple thereof.

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOUR CHILDREN:

  Attained age at death:

  Live birth to 14 days: $1,000
  14 days to 6 months: $1,000
  6 months to age 19 or to age 26 if a full-time student:

  The lesser of:
  - 100% of your amount of insurance; or
  - $10,000.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

  Accelerated Benefit
  Conversion
  Continuity of Coverage
  Portability

NOTE: Portability under this plan is available to an insured spouse in the event of divorce from an insured employee, subject to all terms and conditions otherwise applicable to ported spouse coverage.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.
BENEFITS AT A GLANCE

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN

This accidental death and dismemberment insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death or for you in the event of any other covered loss. The amount you or your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death or any other covered loss according to the terms and provisions of the plan. You also have the opportunity to have coverage for your dependents.

EMPLOYER'S ORIGINAL PLAN

EFFECTIVE DATE: October 1, 2015

PLAN YEAR:

October 1, 2015 to January 1, 2016 and each following January 1 to January 1

POLICY NUMBER: 469871 001

ELIGIBLE GROUP(S):

All Full-Time Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Staff Employees
Employees who are working at least 1000 hours or more per year.

Faculty Employees
Employees who are actively working for the policyholder teaching .5 FTE’s (full-time equivalents) or more per year.

Faculty Employees who are appointed to an Administrative Assignment
Employees who are actively working for the policyholder at least .5 FTE’s (full-time equivalents) or more per year.

WAITING PERIOD:

For employees in an eligible group on or before October 1, 2015: None

For employees entering an eligible group after October 1, 2015: First of the month coincident with or next following the date you enter an eligible group

REHIRE:

If your employment ends and you are rehired within 90 days, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

For You:
You pay the cost of your coverage.

For Your Dependents:
You pay the cost of your dependent coverage.
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT:

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU
(FULL AMOUNT)

Amounts in $10,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $10,000, if not already an exact multiple thereof.

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE AVAILABLE IF YOU
BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

If you have reached age 70, but not age 75, your amount of AD&D insurance will be:
- 65% of the amount of AD&D insurance you had prior to age 70; or
- 65% of the amount of AD&D insurance shown above if you become insured on or after age 70 but before age 75.

There will be no further increases in your amount of AD&D insurance.

If you have reached age 75 or more, your amount of AD&D insurance will be:
- 50% of the amount of AD&D insurance you had prior to your first reduction; or
- 50% of the amount of AD&D insurance shown above if you become insured on or after age 75.

There will be no further increases in your amount of AD&D insurance.

MAXIMUM BENEFIT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE FOR YOU:

The lesser of:
- 5 x annual earnings; or
- $500,000.

AMOUNT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE FOR YOUR
DEPENDENTS (FULL AMOUNT)

Spouse:

Amounts in $5,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $5,000, if not already an exact multiple thereof.

THE AMOUNT OF YOUR SPOUSE’S AD&D INSURANCE WILL REDUCE BY THE SAME
PERCENTAGE AND AT THE SAME TIME YOUR AD&D INSURANCE REDUCES.

MAXIMUM BENEFIT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE FOR YOUR
SPOUSE:

The lesser of:
- 100% of your amount of insurance; or
- $500,000.

Children:

Amounts in $1,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $1,000, if not already a multiple thereof.

MAXIMUM BENEFIT OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE FOR YOUR
CHILDREN:

Attained age at death:

Live birth to 14 days: $1,000
14 days to 6 months: $1,000
6 months to age 19 or to age 26 if a full-time student:

The lesser of:
- 100% of your amount of insurance; or
- $10,000.

**REPATRIATION BENEFIT FOR YOU AND YOUR DEPENDENTS**

Maximum Benefit Amount:

Up to $5,000

The Repatriation Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Repatriation Benefit, your or your dependent's accidental death benefit must be paid first.

**SEATBELT(S) AND AIR BAG BENEFIT FOR YOU AND YOUR DEPENDENTS**

Benefit Amount:

Seatbelt(s): 10% of the Full Amount of your or your dependent's accidental death and dismemberment insurance benefit.

Air Bag: 5% of the Full Amount of your or your dependent's accidental death and dismemberment insurance benefit.

Maximum Benefit Payment:

Seatbelt(s): $25,000
Air bag: $5,000

The Seatbelt(s) and Air Bag Benefit is separate from any accidental death and dismemberment benefit which may be payable. To receive the Seatbelt(s) and Air Bag Benefit, your or your dependent's accidental death benefit must be paid first.

**EDUCATION BENEFIT**

Each Qualified Child

Benefit Amount per Academic Year for which a Qualified Child is enrolled:

6% of the Full Amount of the employee's accidental death and dismemberment insurance to a maximum of $6,000.

Maximum Benefit Payments:

4 per lifetime

Maximum Benefit Amount:

$24,000

Maximum Benefit Period:

6 years from the date the first benefit payment has been made.

The Education Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Education Benefit, your accidental death benefit must be paid first.
EXPOSURE AND DISAPPEARANCE BENEFIT FOR YOU AND YOUR DEPENDENTS

Maximum Benefit Amount: The Full Amount

CHILD CARE BENEFIT

Each Qualified Child

Annual Benefit Amount:

Birth through age 13

The lesser of:

- 5% of the Full Amount of your or your spouse's accidental death and dismemberment insurance; or
- $3,000

Maximum Benefit Amount:

$12,000

Maximum Benefit Period:

4 consecutive years

If, at the time of your or your spouse's death, you have no Qualified Child eligible for the Child Care Benefit, we will pay 5% of the Full Amount to a maximum benefit of $2,000 to you, your spouse, your beneficiary or your or your spouse's authorized representative.

The Child Care Benefit is separate from any accidental death and dismemberment benefit which may be payable. In order for your Qualified Child to receive the Child Care Benefit, your or your spouse's accidental death benefit must be paid first.

This benefit will only be paid once per accident, even if you and your spouse suffers an injury in the same accident

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Portability

NOTE: Portability under this plan is available to an insured spouse in the event of divorce from an insured employee, subject to all terms and conditions otherwise applicable to ported spouse coverage.

Continuity of Coverage is available under this plan - refer to the ACCIDENTAL DEATH AND DISMEMBERMENT OTHER BENEFIT FEATURES for further details.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.
CLAIM INFORMATION
LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on your disability, written notice and proof of claim must be sent no later than 90 days after the end of the elimination period.

If a claim is based on death, written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

If you have a disability, you must notify us immediately when you return to work in any capacity, regardless of whether you are working for your Employer.

HOW DO YOU FILE A CLAIM FOR A DISABILITY?

You or your authorized representative, and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

If your claim is based on your disability, your proof of claim, provided at your expense, must show:

- that you are under the regular care of a physician;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation; and
- the name and address of any hospital or institution where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.
If claim is based on death, proof of claim, provided at your or your authorized representative’s expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim or proof of continuing disability. Unum will deny your claim if the appropriate information is not submitted.

**WHEN CAN UNUM REQUEST AN AUTOPSY?**

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

**HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? ** *(Beneficiary Designation)*

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum’s option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.
In addition, if you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse should name a beneficiary according to the requirements specified above for you.

**HOW WILL UNUM MAKE PAYMENTS?**

If your or your dependent’s life claim is at least $10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, you or your beneficiary may request the life claim to be paid according to one of Unum’s other settlement options. This request must be in writing in order to be paid under Unum’s other settlement options.

If you do not survive your spouse, and dependent life coverage is continued, then your surviving spouse’s death claim will be paid to your surviving spouse’s beneficiary.

All other benefits will be paid to you.

**WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?**

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

**WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)**

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an “assignee”); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.
We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s’) provisions before receiving and registering an assignment.
CLAIM INFORMATION

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

If a claim is based on death or other covered loss, written notice and proof of claim must be sent no later than 90 days after the date of death or the date of any other covered loss.

If a claim is based on the Education Benefit, written notice and proof of claim must be sent no later than 60 days after the date of your death.

If it is not possible to give proof within these time limits, it must be given no later than 1 year after the time proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

HOW DO YOU FILE A CLAIM FOR A COVERED LOSS?

You or your authorized representative and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF CLAIM?

If claim is based on death or other covered loss, proof of claim for death or covered loss, provided at your or your authorized representative's expense, must show:

- the cause of death or covered loss;
- the extent of the covered loss;
- the date of covered loss; and
- the name and address of any hospital or institution where treatment was received, including all attending physicians.

Also, in case of death, a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim. Unum will deny your claim if the appropriate information is not submitted.

If a claim is based on the Education Benefit, proof of claim, provided at your authorized representative’s expense, must show:
- the date of enrollment of your qualified child in an accredited post-secondary institution of higher learning;
- the name of the institution;
- a list of courses for the current academic term; and
- the number of credit hours for the current academic term.

**WHEN CAN UNUM REQUEST AN AUTOPSY?**

In the case of death, Unum will have the right and opportunity to request an autopsy where not forbidden by law.

**HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)**

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your accidental death and dismemberment insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

In addition, if you do not survive your spouse, and dependent accidental death and dismemberment coverage is continued, then your surviving spouse should name a beneficiary according to the requirements specified above for you.
HOW WILL UNUM MAKE PAYMENTS?

If your or your dependent's accidental death or dismemberment claim is at least $10,000 Unum will make available to you or your beneficiary a retained asset account (the Unum Security Account).

Payment for the accidental death or dismemberment claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the accidental death or dismemberment claim is less than $10,000, Unum will pay it in one lump sum to you or your beneficiary.

Also, you or your beneficiary may request the accidental death claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

The Child Care Benefit will be paid to you, your spouse, your beneficiary or your or your spouse's authorized representative.

The Education Benefit will be paid to your qualified child or the qualified child's legal representative.

If you do not survive your spouse, and dependent accidental death and dismemberment coverage is continued, then your surviving spouse's death claim will be paid to your surviving spouse's beneficiary.

All other benefits will be paid to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS? (Assignability Rights)

The rights provided to you by the plan(s) for accidental death insurance benefits are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:
the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s’) provisions before receiving and registering an assignment.
POLICYHOLDER PROVISIONS

WHAT IS THE COST OF THIS INSURANCE?

LIFE INSURANCE

Premium payments are *required* for an insured while he or she is disabled under this plan.

The initial premium for each *plan* is based on the initial rate(s) shown in the Rate Information Amendment(s).

PREMIUM WAIVER

Unum does not require premium payments for an insured employee's life coverage if he or she is under age 60 and disabled for 180 days. Proof of disability, provided at the insured employee’s expense, must be filed by the insured employee and approved by Unum.

Also, Unum does not require premium payments for dependents when Unum approves an insured employee’s claim for premium waiver of life insurance. Unum does not require further premium payments for dependents during the period the life insurance premium is waived.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

The initial premium for each *plan* is based on the initial rate(s) shown in the Rate Information Amendment(s).

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

WHEN IS PREMIUM DUE FOR THIS POLICY?

Premium Due Dates: Premium due dates are based on the Premium Due Dates shown in the Rate Information Amendment(s).

The Policyholder must send all premiums to Unum on or before their respective due date. The premium must be paid in United States dollars.

WHEN ARE INCREASES OR DECREASES IN PREMIUM DUE?

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.
If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Unum will only adjust premium for the current policy year and the prior policy year. In the case of fraud, premium adjustments will be made for all policy years.

**WHAT INFORMATION DOES UNUM REQUIRE FROM THE POLICYHOLDER?**

The Policyholder must provide Unum with the following on a regular basis:

- information about employees:
  - who are eligible to become insured;
  - whose amounts of coverage change; and/or
  - whose coverage ends;
- occupational information and any other information that may be required to manage a claim; and
- any other information that may be reasonably required.

Policyholder records that, in Unum's opinion, have a bearing on this policy will be available for review by Unum at any reasonable time.

Clerical error or omission by Unum will not:

- prevent an employee from receiving coverage;
- affect the amount of an insured's coverage; or
- cause an employee's coverage to begin or continue when the coverage would not otherwise be effective.

**WHO CAN CANCEL OR MODIFY THIS POLICY OR A PLAN UNDER THIS POLICY?**

This policy or a plan under this policy can be cancelled:

- by Unum; or
- by the Policyholder.

Unum may cancel or modify this policy or a plan if:

- the number of employees insured is less than 10 lives or 20% of those eligible, whichever is greater; or
- the Policyholder does not promptly provide Unum with information that is reasonably required; or
- the Policyholder fails to perform any of its obligations that relate to this policy; or
- the premium is not paid in accordance with the provisions of this policy that specify whether the Policyholder, the employee, or both, pay the premiums; or
- the Policyholder does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Policyholder and/or its employees; or
- the Policyholder fails to pay any portion of the premium within the 31 day grace period.
If Unum cancels or modifies this policy or a plan, for reasons other than the Policyholder's failure to pay premium, a written notice will be delivered to the Policyholder at least 31 days prior to the cancellation date or modification date. The Policyholder may cancel this policy or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify this policy or a plan automatically at the end of the grace period. The Policyholder is liable for premium for coverage during the grace period. The Policyholder must pay Unum all premium due for the full period each plan is in force.

The Policyholder may cancel this policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Policyholder and Unum agree, this policy or a plan can be cancelled on a earlier date. If Unum or the Policyholder cancels this policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If this policy or a plan is cancelled, the cancellation will not affect a payable claim.

WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE UNDER THIS POLICY WHILE HE OR SHE IS ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?

We will continue the employee's coverage in accordance with the Employer's Human Resource policy on family and medical leaves of absence if premium payments continue and the Employer approved the employee's leave in writing.

Coverage will be continued until the end of the latest of:

- the leave period required by the federal Family and Medical Leave Act of 1993, and any amendments; or
- the leave period required by applicable state law; or
- the leave period provided to the employee for injury or sickness.

If the Employer's Human Resource policy doesn't provide for continuation of a plan for an employee during a family and medical leave of absence, the employee's coverage will be reinstated when he or she returns to active employment.

We will not:

- apply a new waiting period; or
- require evidence of insurability.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:

FOR LIFE INSURANCE:

NAME/LOCATION (CITY AND STATE)

The Middlebury Institute for International Studies at Monterey
Middlebury, Vermont
FOR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE:

NAME/LOCATION (CITY AND STATE)

The Middlebury Institute for International Studies at Monterey
Middlebury, Vermont
CERTIFICATE SECTION

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the Policyholder), the policy will govern. The policy may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the policy. Any other person, including an agent, may not change the policy or waive any part of it.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
IMPORTANT INFORMATION REGARDING
THE ACCELERATED BENEFIT

The insurance evidenced by this certificate provides life insurance, with the accelerated benefit option (An accelerated payment of your or your dependent's death benefit).

- This accelerated benefit product is NOT a long-term care policy.

- Accelerated benefits paid under the policy may be taxable and assistance should be sought from a personal tax advisor.

- The receipt of the accelerated benefit may affect your eligibility for government programs.

- Your or your dependent's amount of life insurance will be reduced by the accelerated benefit payment.

- If you qualify for premium waiver, your life insurance will be continued without further premium payments according to the terms of the policy.
GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your waiting period.

WHEN DOES YOUR LIFE INSURANCE COVERAGE BEGIN?

This plan provides benefit units that you can choose. When you first become eligible for coverage, you may apply for any number of benefit units, however, you cannot be covered for more than the maximum benefit available under the plan.

Evidence of insurability is required for any amount of life insurance over the amount shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

You pay 100% of the cost yourself for any benefit unit. You will be covered at 12:01 a.m. on the later of:

- the first of the month coincident with or next following the date you are eligible for coverage, if you apply for insurance on or before that date, for any amount of insurance that is not subject to evidence of insurability requirements; or
- the first of the month coincident with or next following the date you apply for insurance, if you apply within 31 days after your eligibility date, for any amount of insurance that is not subject to evidence of insurability requirements; and
- the first of the month coincident with or next following the date Unum approves your evidence of insurability form, if you apply for insurance on or before your eligibility date or within 31 days after your eligibility date, for any amount of insurance that is subject to evidence of insurability requirements.

WHEN CAN YOU APPLY FOR LIFE INSURANCE COVERAGE IF YOU APPLY MORE THAN 31 DAYS AFTER YOUR ELIGIBILITY DATE?

You can apply for coverage only during an annual enrollment period. Evidence of insurability is required for any amount of insurance.

Unum and your Employer determine when the annual enrollment period begins and ends. Coverage applied for during an annual enrollment period will begin at 12:01 a.m. on the later of:

- the first day of the next plan year; or
- the first of the month coincident with or next following the date Unum approves your evidence of insurability form.

**WHEN CAN YOU CHANGE YOUR LIFE INSURANCE COVERAGE?**

You can change your coverage by applying for additional benefit units during an annual enrollment period. You can increase your coverage any number of benefit units up to the maximum benefit available under the plan.

Evidence of insurability is required for any amount of life insurance over the amount shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

Unum and your Employer determine when the annual enrollment period begins and ends. A change in coverage that is made during an annual enrollment period will begin at 12:01 a.m. on:

- the first day of the next plan year for any amount of insurance that is not subject to evidence of insurability requirements; and
- the first of the month coincident with or next following the date Unum approves your evidence of insurability form for any amount of insurance that is subject to evidence of insurability requirements.

In addition, you can decrease your coverage any number of benefit units during the plan year or annual enrollment period. Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

**WHEN DOES YOUR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE COVERAGE BEGIN?**

This plan provides benefit units that you can choose. When you first become eligible for coverage, you may apply for any number of benefit units, however, you cannot be covered for more than the maximum benefit available under the plan.

You pay 100% of the cost yourself for any benefit unit. You will be covered at 12:01 a.m. on the later of:

- the first of the month coincident with or next following the date you are eligible for coverage, if you apply for insurance on or before that date; or
- the first of the month coincident with or next following the date you apply for insurance, if you apply within 31 days after your eligibility date.

**WHEN CAN YOU APPLY FOR ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE COVERAGE IF YOU APPLY MORE THAN 31 DAYS AFTER YOUR ELIGIBILITY DATE?**

You can apply for accidental death and dismemberment insurance coverage only during an annual enrollment period.

Unum and your Employer determine when the annual enrollment period begins and ends. Coverage applied for during an annual enrollment period will begin at 12:01 a.m. on the first day of the next plan year.
WHEN CAN YOU CHANGE YOUR ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE?

You can change your coverage by applying for additional benefit units during an annual enrollment period. You can increase your coverage any number of benefit units up to the maximum benefit available under the plan.

Unum and your Employer determine when the annual enrollment period begins and ends. A change in coverage that is made during an enrollment period will begin at 12:01 a.m. on the first day of the next plan year.

In addition, you can decrease your coverage any number of benefit units during the plan year or annual enrollment period. Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the first of the month coincident with or next following the date you return to active employment.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE NOT WORKING DUE TO INJURY OR SICKNESS?

If you are not working due to injury or sickness, and if premium is paid, you may continue to be covered up to your retirement date.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary layoff, and if premium is paid, you will be covered through the end of the month that immediately follows 60 days from the date your temporary layoff begins.

If you are on a parental leave of absence, and if premium is paid, you will be covered in accordance with your Employer's policy on leaves of absence.

If you are on any other leave of absence, and if premium is paid, you will be covered for up to 12 months following the date your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage due to a change in your annual earnings or due to a plan change requested by your Employer will take effect on the first of the month coincident with or next following the date the change occurs or on the first of the month coincident with or next following the date Unum approves your evidence of insurability form, if evidence of insurability is required. You must be in active employment or on a covered layoff or leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional coverage due to a change in your annual earnings or due to a plan
change will begin on the first of the month coincident with or next following the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the Policy or a plan ends on the earliest of:

- the date the Policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Unum will provide coverage for a payable claim which occurs while you are covered under the Policy or plan.

WHEN ARE YOU ELIGIBLE TO ELECT DEPENDENT COVERAGE?

If you elect coverage for yourself or are insured under the plan, you are eligible to elect dependent coverage for your spouse only, your dependent children only or both.

WHEN ARE YOUR DEPENDENTS ELIGIBLE FOR COVERAGE?

The date your dependents are eligible for coverage is the later of:

- the date your insurance begins; or
- the date you first acquire a dependent.

WHAT DEPENDENTS ARE ELIGIBLE FOR COVERAGE?

The following dependents are eligible for coverage under the plan:

- Your lawful spouse, including a legally separated spouse. You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.

"Spouse" wherever used includes domestic partner.

- Your domestic partner. Your domestic partner is the person named in your declaration of domestic partnership. You must execute and provide the plan administrator with such a declaration which states and gives proof that the domestic partner has had the same permanent residence as you for a minimum of 6 consecutive months prior to the date insurance would become effective for that domestic partner. You must not have signed a declaration of domestic partnership with anyone else within the last 6 months of signing the latest declaration of domestic partnership. Also, the domestic partner must be at least 18 years of age, competent to contract, not related by blood closer than would bar marriage, the sole named domestic partner, not married to anyone else and the declaration of domestic partnership must be approved and recorded by the plan administrator.
You may not cover your domestic partner as a dependent if your domestic partner is enrolled for coverage as an employee.

- Your unmarried children from live birth but less than age 19. Stillborn children are not eligible for coverage.

- Your unmarried dependent children age 19 or over but under age 26 also are eligible if they are full-time students at an accredited school.

- Your unmarried handicapped dependent children age 26 or over who became handicapped prior to the child's attainment of age 26.

Unum must receive proof within 31 days of the date the child is eligible for coverage under the policy, and as required during the first two years. After the first two years, Unum will ask for proof when needed, but not more than once a year.

Children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

No dependent child may be covered by more than one employee in the plan.

No dependent child can be covered as both an employee and a dependent.

**WHEN DOES YOUR DEPENDENT LIFE INSURANCE COVERAGE BEGIN?**

This plan provides benefit units that you can choose for your dependents. When your dependents first become eligible for coverage, you may apply for any number of benefit units, however, your dependents cannot be covered for more than the maximum benefits available under the plan.

**Evidence of insurability** is required for any amount of dependent life insurance over the amount shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

You pay 100% of the cost yourself for dependent coverage. Your dependents will be covered at 12:01 a.m. on the later of:

- the first of the month coincident with or next following the date your dependents are eligible for coverage, if you apply for dependent insurance on or before that date, for any amount of insurance that is not subject to evidence of insurability requirements; or
- the first of the month coincident with or next following the date you apply for dependent insurance, if you apply for dependent insurance within 31 days after your dependent's eligibility date, for any amount of insurance that is not subject to evidence of insurability requirements; and
- the first of the month coincident with or next following the date Unum approves your dependent's evidence of insurability form, if you apply for dependent insurance on or before your dependent's eligibility date or within 31 days after your dependent's eligibility date for any amount of insurance that is subject to evidence of insurability requirements.
WHEN CAN YOU APPLY FOR DEPENDENT LIFE INSURANCE COVERAGE IF YOU APPLY MORE THAN 31 DAYS AFTER YOUR DEPENDENT'S ELIGIBILITY DATE?

You can apply for dependent coverage only during an annual enrollment period. Evidence of insurability is required for any amount of dependent life insurance over the amount shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page. Unum and your Employer determine when the annual enrollment period begins and ends. Dependent coverage applied for during an annual enrollment period will begin on the later of:

- the first day of the next plan year for any amount of insurance that is not subject to evidence of insurability requirements; and
- the first of the month coincident with or next following the date Unum approves your dependent's evidence of insurability form for any amount of insurance that is subject to evidence of insurability requirements.

WHEN CAN YOU CHANGE YOUR DEPENDENT LIFE INSURANCE COVERAGE?

You can change your dependent coverage by applying for additional benefit units during an annual enrollment period. You can increase your dependent coverage any number of benefit units up to the maximum benefits available under the plan.

Evidence of insurability is required for any amount of dependent life insurance over the amount shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

Unum and your Employer determine when the annual enrollment period begins and ends. A change in dependent coverage that is made during an annual enrollment period will begin at 12:01 a.m. on:

- the first day of the next plan year for any amount of insurance that is not subject to evidence of insurability requirements; and
- the first of the month coincident with or next following the date Unum approves your dependent's evidence of insurability form for any amount of insurance that is subject to evidence of insurability requirements.

In addition, you can decrease your dependent coverage any number of benefit units during the plan year or annual enrollment period. Any decrease in dependent coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHEN DOES YOUR DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE COVERAGE BEGIN?

This plan provides benefit units that you can choose for your dependents. When your dependents first become eligible for coverage, you may apply for any number of benefit units, however, your dependents cannot be covered for more than the maximum benefits available under the plan.

You pay 100% of the cost yourself for dependent coverage. Your dependents will be covered at 12:01 a.m. on the later of:

- the first of the month coincident with or next following the date your dependents are eligible for coverage, if you apply for dependent insurance on or before that date; or
the first of the month coincident with or next following the date you apply for dependent insurance, if you apply within 31 days after your dependent’s eligibility date.

WHEN CAN YOU APPLY FOR DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE COVERAGE IF YOU APPLY MORE THAN 31 DAYS AFTER YOUR DEPENDENTS’ ELIGIBILITY DATE?

You can apply for dependent coverage only during an annual enrollment period.

Unum and your Employer determine when the annual enrollment period begins and ends. Dependent coverage applied for during an annual enrollment period will begin at 12:01 a.m. on the first day of the next plan year.

WHEN CAN YOU CHANGE YOUR DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE?

You can change your dependent coverage by applying for additional benefit units during an annual enrollment period. You can increase your dependent coverage any number of benefit units up to the maximum benefits available under the plan.

Unum and your Employer determine when the annual enrollment period begins and ends. A change in coverage that is made during an annual enrollment period will begin at 12:01 a.m. on the first day of the next plan year.

In addition, you can decrease your dependent coverage any number of benefit units during the plan year or annual enrollment period. Any decrease in dependent coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHAT IF YOUR DEPENDENT IS TOTALLY DISABLED ON THE DATE YOUR DEPENDENT’S COVERAGE WOULD NORMALLY BEGIN?

If your eligible dependent is totally disabled, your dependent’s coverage will begin on the first of the month coincident with or next following the date your eligible dependent no longer is totally disabled. This provision does not apply to a newborn child while dependent insurance is in effect.

WHEN WILL CHANGES TO YOUR DEPENDENT’S COVERAGE TAKE EFFECT?

Once your dependent's coverage begins, any increased or additional dependent coverage due to a plan change requested by your Employer will take effect on the first of the month coincident with or next following the date the change occurs or on the first of the month coincident with or next following the date Unum approves your dependent's evidence of insurability form, if evidence of insurability is required, provided your dependent is not totally disabled. You must be in active employment or on a covered layoff or leave of absence.

If you are not in active employment due to injury or sickness, any increased or additional dependent coverage due to a plan change will begin on the first of the month coincident with or next following the date you return to active employment.
If your dependent is totally disabled, any increased or additional dependent coverage will begin on the first of the month coincident with or next following the date your dependent is no longer totally disabled.

Any decreased coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

**WHEN DOES YOUR DEPENDENT'S COVERAGE END?**

Your dependent's coverage under the Policy or a plan ends on the earliest of:

- the date the Policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the date of your death;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in this certificate of coverage.

Coverage for any one dependent will end on the earliest of:

- the date your coverage under a plan ends;
- the date your dependent ceases to be an eligible dependent;
- for a spouse, the date of divorce or annulment; or
- for a domestic partner, the date your domestic partnership ends.

Unum will provide coverage for a payable claim which occurs while your dependents are covered under the Policy or plan.

**WILL COVERAGE CONTINUE FOR A HANDICAPPED CHILD INSURED UNDER THE PLAN WHO IS AGE 26 OR OVER?**

Coverage will continue for a child age 26 or over who is handicapped, provided:

- the child is currently insured under the plan; and
- the child is unmarried; and
- you are the main source of support and maintenance.

Unum must receive proof within 31 days of the date the child attains 26 and as required during the first two years. After the first two years, Unum will ask for proof when needed, but not more than once a year.

**WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?**

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

**HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?**

Unum considers any statements you or your Employer make in a signed application for coverage or an evidence of insurability form a representation and not a warranty.
If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application or an evidence of insurability form as a basis for doing this.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

**HOW WILL UNUM HANDLE INSURANCE FRAUD?**

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

**DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?**

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

**DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?**

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.
LIFE INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOU IF UNUM APPROVES YOUR DEPENDENT’S DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

WHAT ARE YOUR ANNUAL EARNINGS?

Annual Contract and Salaried Employees
"Annual Earnings" means your annual contract salary in effect just prior to your date of loss. Annual Salary is your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

Hourly Employees
"Annual Earnings" means your annual income from your Employer in effect just prior to your date of loss. It is figured by multiplying the current hourly rate of pay multiplied by the number of hours you are regularly scheduled to work per year, but not more than 2080 hours.

If you do not have regular work hours, "Annual Earnings" will be the lesser of:

a. the 12 calendar month period of your employment with your Employer just prior to the date of loss; or

b. the period of actual employment with your Employer.

Average hours will not be more than 2080 hours per year.

It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions,
bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

**Employees Participating in the Employer's Phased Retirement Policy**

"Annual Earnings" is gross annual income from your Employer in effect just prior to the date you enter the Phased Retirement Agreement with your Employer. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It is also prior to any elective pre-tax contributions to your Employer's Nonqualified Deferred Compensation Plan. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

**WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?**

If you become disabled while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

**WHAT HAPPENS TO YOUR LIFE INSURANCE COVERAGE IF YOU BECOME DISABLED?**

Your life insurance coverage may be continued for a specific time and your life insurance premium will be waived if you qualify as described below.

**HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO HAVE LIFE PREMIUMS WAIVED?**

You must be disabled through your elimination period.

Your elimination period is 180 days.

**WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER BEGIN?**

Your life insurance premium waiver will begin when we approve your claim, if the elimination period has ended and you meet the following conditions. Your Employer may continue premium payments until Unum notifies your Employer of the date your life insurance premium waiver begins.

Your life insurance premium will be waived if you meet these conditions:

- you are less than 60 and insured under the plan.
- you become disabled and remain disabled during the elimination period.
- you meet the notice and proof of claim requirements for disability while your life insurance is in effect or within three months after it ends.
- your claim is approved by Unum.

After we approve your claim, Unum does not require further premium payments for you while you remain disabled according to the terms and provisions of the plan.

Your life insurance amount will not increase while your life insurance premiums are being waived. Your life insurance amount will reduce or cease at any time it would reduce or cease if you had not been disabled.
WHEN WILL YOUR LIFE INSURANCE PREMIUM WAIVER END?

The life insurance premium waiver will automatically end if:

- you recover and you no longer are disabled;
- you fail to give us proper proof that you remain disabled;
- you refuse to have an examination by a physician chosen by Unum;
- you reach age 65; or
- premium has been waived for 12 months and you are considered to reside outside the United States or Canada. You will be considered to reside outside the United States or Canada when you have been outside these countries for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- during the elimination period, you are not working in any occupation due to your injury or sickness; and
- after the elimination period, due to the same injury or sickness, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by training, education or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

APPLYING FOR LIFE INSURANCE PREMIUM WAIVER

Ask your Employer for a life insurance premium waiver claim form.

The form has instructions on how to complete and where to send the claim.

WHAT INSURANCE IS AVAILABLE WHILE YOU ARE SATISFYING THE DISABILITY REQUIREMENTS? (See Conversion Privilege)

You may use this life conversion privilege when your life insurance terminates while you are satisfying the disability requirements. Please refer to the conversion privilege below. You are not eligible to apply for this life conversion if you return to work and, again, become covered under the plan.

If an individual life insurance policy is issued to you, any benefit for your death under this plan will be paid only if the individual policy is returned for surrender to Unum. Unum will refund all premiums paid for the individual policy.
The amount of your death benefit will be paid to your named beneficiary for the plan. If, however, you named a different beneficiary for the individual policy and the policy is returned to Unum for surrender, that different beneficiary will not be paid.

If you want to name a different beneficiary for this group plan, you must change your beneficiary as described in the Beneficiary Designation page of this group plan.

**WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)**

When coverage ends under the plan, you and your dependents can convert your coverages to individual life policies, without evidence of insurability. The maximum amounts that you can convert are the amounts you and your dependents are insured for under the plan. You may convert a lower amount of life insurance.

You and your dependents must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- your employment terminates; or
- you or your dependents no longer are eligible to participate in the coverage of the plan.

If you convert to an individual life policy, then return to work, and, again, become insured under the plan, you are not eligible to convert to an individual life policy again. However, you do not need to surrender that individual life policy when you return to work.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. The person may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

**WHAT LIMITED CONVERSION IS AVAILABLE IF THE POLICY OR THE PLAN IS CANCELLED? (Conversion Privilege)**

You and your dependents may convert a limited amount of life insurance if you have been insured under your Employer's group plan with Unum for at least five (5) years and the Policy or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum for each of you will be the lesser of:

- $10,000; or
- your or your dependent's coverage amounts under the plan less any amounts that become available under any other group life plan offered by your Employer within 31 days after the date the Policy or the plan is cancelled.

**PREMIUMS**

Premiums for the converted insurance will be based on:

- the person's then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum's customary rates in use at that time; and
- the class of risk to which the person belongs.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

**DEATH DURING THE THIRTY-ONE DAY CONVERSION APPLICATION PERIOD**

If you or your dependents die within the 31 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

**EMPLOYER NOTICE**

Your Employer must notify each person of their conversion privileges within 15 days from the date that person's life insurance terminates.

If your Employer does not notify that person within those 15 days, but does notify that person within 60 days from the date that person's life insurance terminates, the time allowed for that person to exercise their life conversion privilege will be extended 15 days from the date that person is notified.

If your Employer does not notify that person within those 60 days, the time allowed for that person to exercise that person's life conversion privilege will expire at the end of those 60 days.

**APPLYING FOR CONVERSION**

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

**WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL? (Accelerated Benefit)**

If you or your dependent becomes terminally ill while you or your dependent is insured by the plan, Unum will pay you a portion of your or your dependent's life insurance benefit one time. The payment will be based on 50% of your or your dependent's life insurance amount. However, the one-time benefit paid will not be greater than $750,000.

Your or your dependent's right to exercise this option and to receive payment is subject to the following:
- you or your dependent requests this election, in writing, on a form acceptable to Unum;
- you or your dependent must be terminally ill at the time of payment of the Accelerated Benefit;
- your or your dependent's physician must certify, in writing, that you or your dependent is terminally ill and your or your dependent's life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to Unum.

The Accelerated Benefit cannot be used by you or your dependent if:

- you or your dependent is required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise; or
- you or your dependent is required by a government agency to use this benefit in order to apply for, get, or otherwise keep a government benefit or entitlement.

Premium payments must continue to be paid on the full amount of life insurance unless you qualify to have your life premium waived.

Also, premium payments must continue to be paid on the full amount of your dependent's life insurance unless you qualify to have your life premium waived.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Unum must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Unum before benefits are payable.

An election to receive an Accelerated Benefit will have the following effect on other benefits:

- the death benefit payable will be reduced by any amount of Accelerated Benefit that has been paid; and
- any amount of life insurance that would be continued under a disability continuation provision or that may be available under the conversion privilege will be reduced by the amount of the Accelerated Benefit paid. The remaining life insurance amount will be paid according to the terms of the Policy subject to any reduction and termination provisions.

Benefits paid may be taxable. Unum is not responsible for any tax or other effects of any benefit paid. As with all tax matters, you or your dependent should consult your personal tax advisor to assess the impact of this benefit.

**WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?**

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 24 months after your or your dependent's initial effective date of insurance; and
- suicide occurring within 24 months after the date any increases or additional insurance become effective for you or your dependent.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.
The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you or your dependent applied for at that time.
LIFE INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN THE POLICYHOLDER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you and your dependent(s) if you and your dependent(s) are covered by the prior policy on the day before the effective date of this policy, and if you would be eligible for coverage under this policy if you were in active employment on the effective date of this policy.

If you are on a covered layoff or leave of absence on the effective date of this policy, we will consider your layoff or leave of absence to have started on that date, and coverage for you and your dependent(s) under this provision will continue for the layoff or leave of absence period provided in this policy, or the layoff or leave of absence period remaining under the prior policy on the effective date of this policy, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this policy, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this policy, any benefits payable under this policy will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you and your dependent(s) are subject to payment of required premium and all other terms of this policy, except that the portable insurance coverage terms of this policy will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself and your dependents.

In case of your death, your insured dependents also may elect portable coverage for themselves. However, children cannot become insured for portable coverage unless the spouse also becomes insured for portable coverage.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you and your dependents are insured for under your Employer’s group plan.
However, the amount of portable coverage for you will not be more than:

- the highest amount of life insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for your spouse will not be more than:

- the highest amount of life insurance available for spouses under the plan; or
- 100% of your amount of portable coverage; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for a child will not be more than:

- the highest amount of life insurance available for children under the plan; or
- 100% of your amount of portable coverage; or
- $20,000,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000 for you and $1,000 for your dependents. If the current amounts under the plan are less than $5,000 for you and $1,000 for your dependents you and your dependents may port the lesser amounts.

Your or your dependent's amount of life insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

**APPLYING FOR PORTABLE COVERAGE**

You must apply for portable coverage for yourself and your dependents and pay the first premium within 31 days after the date:

- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.
Your dependents must apply for portable coverage and pay the first premium within 31 days after the date you die.

You are not eligible to apply for portable coverage for yourself if:

- you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy; or
- you failed to pay the required premium under the terms of this plan.

You are not eligible to apply for portable coverage for a dependent if:

- you do not elect portable coverage for yourself;
- you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your dependent has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy; or
- you failed to pay the required premium under the terms of this plan.

In case of your death, your spouse is not eligible to apply for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy; or
- you failed to pay the required premium under the terms of this plan for your spouse.

In case of your death, your child is not eligible for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse is insured under this plan and chooses not to elect portable coverage;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your child has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy; or
- you failed to pay the required premium under the terms of this plan for your child.

If we determine that because of an injury or sickness, which has a material effect on life expectancy, you or your dependents were not eligible for portability at the time you or your dependents elected portable coverage, the benefit will be adjusted to the amount of whole life coverage the premium would have purchased under the Conversion Privilege.

**APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE**

You or your dependents may increase or decrease the amount of life insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of life insurance coverage cannot be decreased below $5,000 for you and $1,000 for your dependents. All increases are subject to evidence of insurability. Portable coverage will reduce at the ages and amounts shown in the LIFE INSURANCE "BENEFITS AT A GLANCE" page.

**ADDING PORTABLE COVERAGE FOR DEPENDENTS**
If you choose not to enroll your dependents when your dependents were first eligible for portable coverage, you may enroll your dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

You may enroll newly acquired dependents at any time for the amounts allowed under the group plan. Evidence of insurability is required.

**WHEN PORTABLE COVERAGE ENDS**

Portable coverage for you will end on the date you fail to pay any required premium.

Portable coverage for a spouse will end for the following reasons:

- the date you fail to pay any required premium; or
- the date your surviving spouse fails to pay any required premium.

Portable coverage for a child will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium;
- the date your child no longer qualifies as a dependent; or
- the date the surviving spouse dies.

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

**PREMIUM RATE CHANGES FOR PORTABLE COVERAGE**

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.

**APPLYING FOR CONVERSION, IF PORTABLE COVERAGE ENDS OR IS NOT AVAILABLE**

If you or your dependent is not eligible to apply for portable coverage or portable coverage ends, then you or your dependent may qualify for conversion coverage. Refer to Conversion Privilege under this plan.

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT IN THE EVENT OF YOUR DEATH IF YOUR DEATH IS THE DIRECT RESULT OF AN ACCIDENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim providing you meet certain conditions.

WHEN WILL YOU RECEIVE PAYMENT IN THE EVENT OF YOUR DEPENDENT’S DEATH IF YOUR DEPENDENT’S DEATH IS THE DIRECT RESULT OF AN ACCIDENT?

You will receive payment when Unum approves the death claim for your dependent providing certain conditions are met.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF ACCIDENTAL DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

WHEN WILL YOU RECEIVE PAYMENT IN THE EVENT OF CERTAIN OTHER COVERED LOSSES IF THE LOSS IS THE DIRECT RESULT OF AN ACCIDENT?

You will receive payment when Unum approves the claim.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IN THE EVENT OF YOUR ACCIDENTAL DEATH OR YOU FOR YOUR DEPENDENT’S ACCIDENTAL DEATH OR FOR CERTAIN OTHER COVERED LOSSES?

If Unum approves the claim, Unum will determine the payment according to the Covered Losses and Benefits List below. The benefit Unum will pay is listed opposite the corresponding covered loss.

The benefit will be paid only if an accidental bodily injury results in one or more of the covered losses listed below within 365 days from the date of the accident.

Also, the accident must occur while you or your dependent is insured under the plan.

<table>
<thead>
<tr>
<th>Covered Losses</th>
<th>Benefit Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>Both Hands or Both Feet or Sight of Both Eyes</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>One Hand and Sight of One Eye</td>
<td>The Full Amount</td>
</tr>
</tbody>
</table>
One Foot and Sight of One Eye The Full Amount
Speech and Hearing The Full Amount
One Hand or One Foot One Half The Full Amount
Sight of One Eye One Half The Full Amount
Speech or Hearing One Half The Full Amount
Thumb and Index Finger of Same Hand One Quarter The Full Amount

The most Unum will pay for any combination of Covered Losses from any one accident is the full amount.

The Full Amount is the amount shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE "BENEFITS AT A GLANCE" page.

WHAT ARE YOUR ANNUAL EARNINGS?

Annual Contract and Salaried Employees
"Annual Earnings" means your annual contract salary in effect just prior to your date of loss. Annual salary is your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

Hourly Employees
"Annual Earnings" means your gross annual income from your Employer in effect just prior to your date of loss. It is figured by multiplying the current hourly rate of pay multiplied by the number of hours you are regularly scheduled to work per year, but not more than 2080 hours.

If you do not have regular work hours, "Annual Earnings" will be the lesser of:

a. the 12 calendar month period of your employment with your Employer just prior to the date of loss; or

b. the period of actual employment with your Employer.

Average hours will not be more than 2080 hours per year.

It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.
Employees Participating in the Employer’s Phased Retirement Policy

“Annual Earnings” is gross annual income from your Employer in effect just prior to the date you enter the Phased Retirement Agreement with your Employer. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It is also prior to any elective pre-tax contributions to your Employer's Nonqualified Deferred Compensation Plan. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

WHAT WILL WE USE FOR ANNUAL EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?

If you have an accidental bodily injury that results in one or more of the covered losses while you are on a covered layoff or leave of absence, we will use your annual earnings from your Employer in effect just prior to the date your absence began.

WHAT REPATRIATION BENEFIT WILL UNUM PROVIDE?

Unum will pay an additional benefit for the preparation and transportation of your or your dependent’s body to a mortuary chosen by you or your authorized representative. Payment will be made if, as the result of a covered accident, you or your dependent suffers loss of life at least 100 miles away from your or your dependent’s principal place of residence.

However, when combined with two or more Unum accidental death and dismemberment insurance plans, the combined overall maximum for these plans together cannot exceed the actual expenses for the preparation and transportation of your or your dependent's body to a mortuary.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE "BENEFITS AT A GLANCE" page.

WHAT SEATBELT(S) AND AIR BAG BENEFIT WILL UNUM PROVIDE?

Unum will pay you or your authorized representative an additional benefit if you or your dependent sustains an accidental bodily injury which causes your or your dependent's death while you or your dependent is driving or riding in a Private Passenger Car, provided:

For Seatbelt(s):
- the Private Passenger Car is equipped with seatbelt(s); and
- the seatbelt(s) were in actual use and properly fastened at the time of the covered accident; and
- the position of the seatbelt(s) are certified in the official report of the covered accident, or by the investigating officer. A copy of the police accident report must be submitted with the claim.

Also, if such certification is not available, and it is clear that you or your dependent was properly wearing seatbelt(s), then we will pay the additional seatbelt benefit.
However, if such certification is not available, and it is unclear whether you or your dependent was properly wearing seatbelt(s), then we will pay a fixed benefit of $1,000.

We will only pay the seatbelt benefit for the death of a minor, dependent child, if the child is correctly strapped and fastened in the appropriate seat for the child's age and weight as defined by state or federal guidelines. The seatbelt device must also be approved by the state or federal government for the dependent child's age and weight.

An automatic harness seatbelt will not be considered properly fastened unless a lap belt is also used.

For Air Bag:
- the Private Passenger Car is equipped with an air bag for the seat in which you or your dependents are seated; and
- the seatbelt(s) must be in actual use and properly fastened at the time of the covered accident.

No benefit will be paid if you or your dependent is the driver of the Private Passenger Car and does not hold a current and valid driver's license.

No benefit will be paid if Unum is able to verify that the air bag(s) had been disengaged prior to the accident.

The accident causing your or your dependent's death must occur while you or your dependent is insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT "BENEFITS AT A GLANCE" page.

**WHAT EDUCATION BENEFIT WILL UNUM PROVIDE FOR YOUR QUALIFIED CHILDREN?**

Unum will pay your authorized representative on behalf of each of your qualified children a lump sum payment if:

- you lose your life:
  - as a result of an accidental bodily injury; and
  - within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your accidental bodily injury occurred while you were insured under the plan;
- proof is furnished to Unum that the child is a qualified child; and
- the qualified child continues to be enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level.

The benefit amount per academic year, maximum benefit payments, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE "BENEFITS AT A GLANCE" page.
WHEN WILL THE EDUCATION BENEFIT END FOR EACH QUALIFIED CHILD?

The education benefit will terminate for each qualified child on the earliest of the following dates:

- the date your qualified child fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

WHAT COVERAGE FOR EXPOSURE AND DISAPPEARANCE BENEFIT WILL UNUM PROVIDE?

Unum will pay a benefit if you or your dependent sustains an accidental bodily injury and are unavoidably exposed to the elements and suffer a loss.

We will presume you or your dependent suffered loss of life due to an accident if:
- you or your dependent are riding in a common public passenger carrier that is involved in an accident covered under the policy; and
- as a result of the accident, the common public passenger carrier is wrecked, sinks, is stranded, or disappears; and
- your or your dependent's body is not found within 1 year of the accident.

Also, the accident must occur while you or your dependent is insured under the plan.

The maximum benefit amount is shown in the ACCIDENTAL DEATH AND DISMEMBERMENT "BENEFITS AT A GLANCE" page.

WHAT CHILD CARE BENEFIT WILL UNUM PROVIDE?

Unum will pay you, your spouse or your or your spouse's authorized representative on behalf of each of your qualified children an annual benefit amount for child care if:

- you or your spouse die:
  - as a result of an accidental bodily injury; and
  - within 365 days after the date of the accident causing the accidental bodily injury;
- the accident causing your or your spouse's accidental bodily injury occurred while you or your spouse was insured under the plan;
- proof is furnished to Unum that the child is a qualified child.

This benefit will only be paid once per accident, even if you and your spouse suffers an injury in the same accident.

The annual benefit amount, maximum benefit amount and maximum benefit period are shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE "BENEFITS AT A GLANCE" page.

WHEN WILL THE CHILD CARE BENEFIT END FOR EACH QUALIFIED CHILD?

The child care benefit will terminate for each qualified child on the earliest of the following dates:

- the date you, your spouse or your or your spouse's authorized representative fails to furnish proof as required by us;
- the date your qualified child no longer qualifies as a dependent child for any reason except your death; or
- the end of the maximum benefit period.

**WHAT ACCIDENTAL LOSSES ARE NOT COVERED UNDER YOUR PLAN?**

Your plan does not cover any accidental losses caused by, contributed to by, or resulting from:

- suicide, self destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while insane.
- active participation in a riot.
- an attempt to commit or commission of a crime.
- the use of any prescription or non-prescription drug, poison, fume, or other chemical substance unless used according to the prescription or direction of your or your dependent’s physician. This exclusion will not apply to you or your dependent if the chemical substance is ethanol.
- service on full-time active duty in the Armed Forces of any country or international authority.
- travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from it while:
  - it is being used for test or experimental purposes;
  - you or your dependent is operating, learning to operate or serving as a member of the crew;
  - it is being operated by or for or under the direction of any military authority.
  This exclusion does not apply to:
  - transport type aircraft operated by the Military Airlift Command of the United States; or
  - similar air transport service of any other country.
- travel or flight in any aircraft or device for aerial navigation, including boarding or alighting from it, owned or leased by or on behalf of your Employer.
- disease of the body or diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.
- being intoxicated.
- war, declared or undeclared, or any act of war.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN THE POLICYHOLDER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you and your dependent(s) if you and your dependent(s) are covered by the prior policy on the day before the effective date of this policy, and if you would be eligible for coverage under this policy if you were in active employment on the effective date of this policy.

If you are on a covered layoff or leave of absence on the effective date of this policy, we will consider your layoff or leave of absence to have started on that date, and coverage for you and your dependent(s) under this provision will continue for the layoff or leave of absence period provided in this policy, or the layoff or leave of absence period remaining under the prior policy on the effective date of this policy, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this policy, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this policy, any benefits payable under this policy will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you and your dependent(s) are subject to payment of required premium and all other terms of this policy, except that the portable insurance coverage terms of this policy will not apply to coverage provided under this provision.

WHAT COVERAGE IS AVAILABLE IF YOU END EMPLOYMENT OR YOU WORK REDUCED HOURS? (Portability)

If your employment ends with or you retire from your Employer or you are working less than the minimum number of hours as described under Eligible Groups in this plan, you may elect portable coverage for yourself and your dependents.

In case of your death, your insured dependents also may elect portable coverage for themselves. However, children cannot become insured for portable coverage unless the spouse also becomes insured for portable coverage.

PORTABLE INSURANCE COVERAGE AND AMOUNTS AVAILABLE

The portable insurance coverage will be the current coverage and amounts that you and your dependents are insured for under your Employer's group plan.
However, the amount of portable coverage for you will not be more than:
- the highest amount of accidental death and dismemberment insurance available for employees under the plan; or
- 5x your annual earnings; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for your spouse will not be more than:
- the highest amount of accidental death and dismemberment insurance available for spouses under the plan; or
- 100% of your amount of portable coverage; or
- $750,000 from all Unum group life and accidental death and dismemberment plans combined,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The amount of portable coverage for a child will not be more than:
- the highest amount of accidental death and dismemberment insurance available for children under the plan; or
- 100% of your amount of portable coverage; or
- $20,000,

whichever is less.

The amount of ported life insurance must be equal to or greater than the amount of ported accidental death and dismemberment insurance.

The minimum amount of coverage that can be ported is $5,000 for you and $1,000 for your dependents. If the current amounts under the plan are less than $5,000 for you and $1,000 for your dependents you and your dependents may port the lesser amounts.

Your or your dependent's amount of AD&D insurance will reduce or cease at any time it would reduce or cease for your eligible group if you had continued in active employment with your Employer.

**APPLYING FOR PORTABLE COVERAGE**

You must apply for portable coverage for yourself and your dependents and pay the first premium within 31 days after the date:
- your coverage ends or you retire from your Employer; or
- you begin working less than the minimum number of hours as described under Eligible Groups in this plan.

Your dependents must apply for portable coverage and pay the first premium within 31 days after the date you die.

You are not eligible to apply for portable coverage for yourself if:

- you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy; or
- you failed to pay the required premium under the terms of this plan.

You are not eligible to apply for portable coverage for a dependent if:

- you do not elect portable coverage for yourself;
- you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your dependent has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy; or
- you failed to pay the required premium under the terms of this plan.

In case of your death, your spouse is not eligible to apply for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy; or
- you failed to pay the required premium under the terms of this plan for your spouse.

In case of your death, your child is not eligible for portable coverage if:

- your surviving spouse is not insured under this plan;
- your surviving spouse is insured under this plan and chooses not to elect portable coverage;
- your surviving spouse has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy;
- your child has an injury or sickness, under the terms of this plan, which has a material effect on life expectancy; or
- you failed to pay the required premium under the terms of this plan for your child.

**APPLYING FOR INCREASES OR DECREASES IN PORTABLE COVERAGE**

You or your dependents may increase or decrease the amount of AD&D insurance coverage. The minimum and maximum benefit amounts are shown above. However, the amount of accidental death and dismemberment insurance coverage cannot be decreased below $5,000 for you and $1,000 for your dependents. Portable coverage will reduce at the ages and amounts shown in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE "BENEFITS AT A GLANCE" page.

**ADDING PORTABLE COVERAGE FOR DEPENDENTS**

If you choose not to enroll your dependents when your dependents were first eligible for portable coverage, you may enroll your dependents at any time for the amounts allowed under the group plan.
You may enroll newly acquired dependents at any time for the amounts allowed under the group plan.

**WHEN PORTABLE COVERAGE ENDS**

Portable coverage for you will end on the date you fail to pay any required premium.

Portable coverage for a spouse will end for the following reasons:

- the date you fail to pay any required premium; or
- the date your surviving spouse fails to pay any required premium.

Portable coverage for a child will end for the following reasons:

- the date you fail to pay any required premium;
- the date your surviving spouse fails to pay any required premium;
- the date your child no longer qualifies as a dependent; or
- the date the surviving spouse dies.

If portable coverage ends due to failure to pay required premium, portable coverage cannot be reinstated.

**PREMIUM RATE CHANGES FOR PORTABLE COVERAGE**

Unum may change premium rates for portable coverage at any time for reasons which affect the risk assumed, including those reasons shown below:

- changes occur in the coverage levels;
- changes occur in the overall use of benefits by all insureds;
- changes occur in other risk factors; or
- a new law or a change in any existing law is enacted which applies to portable coverage.

The change in premium rates will be made on a class basis according to Unum's underwriting risk studies. Unum will notify the insured in writing at least 31 days before a premium rate is changed.
GLOSSARY

ACCIDENTAL BODILY INJURY means bodily harm caused solely by external, violent and accidental means and not contributed to by any other cause.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT means the total benefit amount for which an individual is insured under this plan subject to the maximum benefit.

ACCREDITED SCHOOL means an accredited post-secondary institution of higher learning for full-time students beyond the 12th grade level.

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:
- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment. Temporary and seasonal workers are excluded from coverage.

ACTIVITIES OF DAILY LIVING means:
- Bathing - the ability to wash oneself either in the tub or shower or by sponge bath with or without equipment or adaptive devices.
- Dressing - the ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn.
- Toileting - the ability to get to and from and on and off the toilet; to maintain a reasonable level of personal hygiene, and to care for clothing.
- Transferring - the ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
- Continence - the ability to either:
  - voluntarily control bowel and bladder function; or
  - if incontinent, be able to maintain a reasonable level of personal hygiene.
- Eating - the ability to get nourishment into the body.

A person is considered unable to perform an activity of daily living if the task cannot be performed safely without another person's stand-by assistance or verbal cueing.

ANNUAL EARNINGS means your annual income received from your Employer as defined in the plan.

ANNUAL ENROLLMENT PERIOD means a period of time before the beginning of each plan year and ending on the plan anniversary date.

COGNITIVELY IMPAIRED means a person has a deterioration or loss in intellectual capacity resulting from injury, sickness, advanced age, Alzheimer's disease or similar
forms of irreversible dementia and needs another person's assistance or verbal cueing for his or her own protection or for the protection of others.

**ELIMINATION PERIOD** means a period of continuous disability which must be satisfied before you are eligible to have your life premium waived by Unum.

**EMPLOYEE** means a person who is in active employment in the United States with the Employer.

**EMPLOYER** means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

**EVIDENCE OF INSURABILITY** means a statement of your or your dependent's medical history which Unum will use to determine if you or your dependent is approved for coverage. Evidence of insurability will be at Unum's expense.

**GAINFUL OCCUPATION** means an occupation that within 12 months of your return to work is or can be expected to provide you with an income that is at least equal to 60% of your annual earnings in effect just prior to the date your disability began.

**GRACE PERIOD** means the period of time following the premium due date during which premium payment may be made.

**HANDICAPPED** means permanently and continuously incapable of self sustaining support by reason of mental or physical incapacity.

**HOSPITAL OR INSTITUTION** means an accredited facility licensed to provide care and treatment for the condition causing your disability.

**INJURY** means:

- for purposes of Portability, a bodily injury that is the direct result of an accident and not related to any other cause.
- for all other purposes, a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

**INSURED** means any person covered under a plan.

**INTOXICATED** means that your or your dependent's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state where the accident occurred.

**LAYOFF** or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

**LIFE INSURANCE BENEFIT** means the total benefit amount for which an individual is insured under this plan subject to the maximum benefit.
LIFE THREATENING CONDITION is a critical health condition that possibly could result in your dependent's loss of life.

LOSS OF A FOOT means that all of the foot is cut off at or above the ankle joint.

LOSS OF A HAND means that all four fingers are cut off at or above the knuckles joining each to the hand.

LOSS OF HEARING means the total and irrecoverable loss of hearing in both ears.

LOSS OF SIGHT means the eye is totally blind and that no sight can be restored in that eye.

LOSS OF SPEECH means the total and irrecoverable loss of speech.

LOSS OF THUMB AND INDEX FINGER means that all of the thumb and index finger are cut off at or above the joint closest to the wrist.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PHYSICIAN means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the policy.

POLICYHOLDER means the Employer to whom the policy is issued.

PRIVATE PASSENGER CAR means a validly registered four-wheel private passenger car (including Employer-owned cars), station wagons, jeeps, pick-up trucks, and vans that are used only as private passenger cars.

QUALIFIED CHILD means:

- for purposes of the Education Benefit, any of your unmarried dependent children under age 25 who, on the date of your death as a result of an accidental bodily injury, was either:

  - enrolled as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level; or
  - at the 12th grade level and enrolls as a full-time student in an accredited post-secondary institution of higher learning beyond the 12th grade level within 365 days following the date of your death.
- for purposes of the Child Care Benefit, any of your unmarried dependent children under age 14 who, were enrolled in a licensed day care facility, school facility, or other similar program for 90 continuous days before the date of the accident causing your death. The Child Care Benefit will not be extended to any of your children born after the date of your death unless pregnancy commenced prior to the date of your death.

Children include your own natural offspring, lawfully adopted children and stepchildren. They also include foster children and other children who are dependent on you for main support and living with you in a regular parent-child relationship. A child will be considered adopted on the date of placement in your home.

REGULAR CARE means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

RETAINED ASSET ACCOUNT is an interest bearing account established through an intermediary bank in the name of you or your beneficiary, as owner.

SICKNESS means:

- for purposes of Portability, an illness, disease or symptoms for which a person, in the exercise of ordinary prudence, would have consulted a health care provider.
- for all other purposes, an illness or disease. Disability must begin while you are covered under the plan.

TOTALLY DISABLED means that, as a result of an injury, a sickness or a disorder:

Your dependent spouse:

- is confined in a hospital or similar institution;
- is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness;
- is cognitively impaired;
- is receiving or is entitled to receive any disability income from any source due to any sickness or injury;
- is receiving chemotherapy, radiation therapy or dialysis treatment;
- is confined at home under the care of a physician for a sickness or injury; or
- has a life threatening condition.

Your dependent children:

- are confined in a hospital or similar institution;
- are receiving chemotherapy, radiation therapy or dialysis treatment; or
- are confined at home under the care of a physician for a sickness or injury.

WAITING PERIOD means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.
YOU means an employee who is eligible for Unum coverage.
THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY THE STATE OF WASHINGTON. PLEASE READ CAREFULLY.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

If you had group life coverage in place with your employer through another carrier when your employer changed carriers to Unum, your prior coverage may be continued under the Unum plan to the extent the laws of your resident state require such right to continue and within the design limits of the Unum plan.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

For residents of Washington

The definition for ACTIVE EMPLOYMENT in the GLOSSARY section is amended to include the following:

A period of up to 6 months during which you are not working due to a strike, lockout or other labor dispute is considered active employment. Your employer may require you to pay premium during this period of time.

The WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL? (Accelerated Benefit) in the Life Insurance Benefit Information section is amended by changing the life expectancy requirement to 24 months or less, or such longer period as stated in the policy.

The WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN? provision in the Life Insurance Benefit Information section is amended to remove any exclusion for death caused by suicide.
AMENDMENT

This amendment forms a part of the Group Policy to which it is attached and issued to the Policyholder:

The provision entitled "WHO CAN CANCEL OR MODIFY THIS POLICY OR A PLAN UNDER THIS POLICY?", in the POLICYHOLDER PROVISIONS section of the policy, is changed to read as follows:

WHO CAN CANCEL OR MODIFY THIS POLICY OR A PLAN UNDER THIS POLICY?

This policy or a plan under this policy can be cancelled:

- by Unum; or
- by the Policyholder.

Unum may cancel or modify this policy or a plan if:

- the Policyholder does not promptly provide Unum with information that is reasonably required;
- the Policyholder fails to perform any of its obligations that relate to this policy;
- fewer than 10 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of this policy that specify whether the Policyholder, the employee, or both, pay(s) the premiums;
- the Policyholder does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its employees; or
- the Employer paid group Life policy, or group Life and Accidental Death and Dismemberment policy, issued by Unum to this Employer terminates.

If Unum cancels or modifies this policy or a plan, for any of the reasons listed above, a written notice will be delivered to the Policyholder at least 31 days prior to the cancellation date or modification date. The Policyholder may cancel this policy or a plan if the modifications are unacceptable.

If any premium is not paid during the 31 day grace period, the policy or plan will terminate automatically at the end of the grace period. The Policyholder is liable for premium for coverage during the grace period. The Policyholder must pay Unum all premium due for the full period this policy is in force. In the event of termination, the policy or plan may be reinstated only as agreed upon by Unum and the Policyholder. If Unum agrees to reinstate the policy or plan, such reinstatement will not constitute waiver of the termination provision in the future.

The Policyholder may cancel this policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Policyholder
and Unum agree, this policy or a plan can be cancelled on an earlier date. If Unum or the Policyholder cancels this policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If this policy or a plan is cancelled, the cancellation will not affect a payable claim.

The effective date of this amendment is October 1, 2015. The policy's terms and provisions will apply other than as stated in this amendment. Dated at Portland, Maine on November 20, 2015.

Unum Life Insurance Company of America

By_______________________________

Secretary
VERMONT MANDATORY CIVIL UNIONS ENDORSEMENT

PURPOSE:

Vermont law requires that health and life insurers recognize parties to a civil union that is equivalent to coverage provided to married persons. This endorsement is part of and amends this policy, contract, certificate, summary of benefits and/or riders and endorsements to comply with Vermont law.

DEFINITIONS, TERMS, CONDITIONS AND PROVISIONS:

The definitions, terms, conditions and any other provisions of this policy, contract, certificate, summary of benefits and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family", "family member" and any other such terms include the relationship created by a civil union established according to Vermont law.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

Terms that mean or refer to family relationships arising from a marriage, such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor", "family member" and any other such terms include family relationships created by a civil union established according to Vermont law.

Where applicable, "dependent" means a spouse, a party to a civil union, and/or a child or children who are born to or brought to a marriage or to a civil union. Child or children include the insured's own natural offspring, lawfully adopted children and stepchildren. A child will be considered adopted on the date of placement in the insured's home. Child or children will also include an unmarried child who is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy or physical handicap and who become so incapable prior to the limiting age and who is dependent on the insured for support and maintenance.

They also may include foster children and other minor children who are dependent on the insured for main support and living with the insured in a regular parent-child relationship.

Where applicable, "child or covered child" includes:

- the insured's own natural offspring, lawfully adopted children and stepchildren. A child will be considered adopted on the date of placement in the insured's home.
- an unmarried child who is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy or physical handicap and who became so incapable prior to the limiting age and who is dependent on the insured for support and maintenance.
They also may include foster children and other minor children who are dependent on the insured for main support and living with the insured in a regular parent-child relationship.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to life and health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as "ERISA", controls the employer/employee relationship with regard to determining eligibility for enrollment in non-exempt private employer welfare benefit plans. Because of ERISA, Vermont Act 91 relating to civil unions does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide benefits to the dependents of a party to a civil union if the public employer provides benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, summary of benefits, rider or endorsement that derive from federal law. You are advised to seek expert advise to determine your rights under this policy, contract, summary of benefits, certificate, and/or riders and endorsements.
ERISA

Additional Summary Plan Description Information

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document.

Name of Plan:
The President and Fellows of Middlebury College Plan

Name and Address of Employer:
The President and Fellows of Middlebury College
Middlebury Human Resources Marble Works
152 Maple Street
Suite 101 - Suite 203 (Benefits)
Middlebury, Vermont
05753

Plan Identification Number:
a. Employer IRS Identification #: 03-0179298
b. Plan #: 501

Type of Welfare Plan:
Life and Accidental Death and Dismemberment

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
The President and Fellows of Middlebury College
Middlebury Human Resources Marble Works
152 Maple Street
Suite 101 - Suite 203 (Benefits)
Middlebury, Vermont
05753
(802) 443-5000

The President and Fellows of Middlebury College is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of
Legal Process on the Plan:
The President and Fellows of Middlebury College
Middlebury Human Resources Marble Works
152 Maple Street
Suite 101 - Suite 203 (Benefits)
Middlebury, Vermont
05753

Service of legal process may also be made upon the Plan Administrator, or a
Trustee of the Plan, if any.

Funding and Contributions:
The Plan is funded by insurance issued by Unum Life Insurance Company of
America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to
as "Unum") under policy number 469871 001. Contributions to the Plan are
made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of
Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend,
modify, or terminate, in whole or in part, any or all of the provisions of the Plan
(including any related documents and underlying policies), at any time and for any
reason or no reason. Any amendment, modification, or termination must be in
writing and endorsed on or attached to the Plan.

EMPLOYER'S RIGHT TO REQUEST POLICY CHANGE

The Employer can request a policy change. Only an officer or registrar of Unum can
approve a change. The change must be in writing and endorsed on or attached to
the policy.

MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY

The policy or a plan under the policy can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the policy or a plan if:

- the number of employees insured is less than 10 lives or 20% of those eligible,
  whichever is greater; or
- the Employer does not promptly provide Unum with information that is reasonably
  required; or
- the Employer fails to perform any of its obligations that relate to the policy; or
- the premium is not paid in accordance with the provisions of the policy that specify
  whether the Employer, the employee, or both, pay the premiums; or
- the Employer does not promptly report to Unum the names of any employees who
  are added or deleted from the eligible group; or
- Unum determines that there is a significant change, in the size, occupation or age
  of the eligible group as a result of a corporate transaction such as a merger,
divestiture, acquisition, sale, or reorganization of the Employer and/or its
employees; or
- the Employer fails to pay any portion of the premium within the 31 day grace period.

If Unum cancels or modifies the policy or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the policy or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the policy or a plan can be cancelled on a earlier date. If Unum or the Employer cancels the policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the policy or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

If a claim is based on death, a covered loss not based on disability or for the Education Benefit

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum’s notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan’s procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.
If a claim is based on your disability

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;

- reference specific Plan provision(s) on which the determination is based;

- describe additional material or information necessary to complete the claim and why such information is necessary;

- describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

If an appeal is based on death, a covered loss not based on disability or for the Education Benefit

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;

- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and

- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require
additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those policy provisions upon which the final decision is based. It will also include a statement describing your right to access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

**If an appeal is based on your disability**

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Unum determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Unum will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a
subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;
- a reference to the specific Plan provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;
- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, 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 summary plan description. 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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 that is denied or ignored, in whole or in part, you may file suit in a state or 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, if, for example, 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, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
This amendment forms a part of the "ERISA Additional Summary Plan Description Information" to which it is attached and issued to the Policyholder.

This amendment changes the section entitled "MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY" to read as follows:

**MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY**

The policy or a plan under the policy can be cancelled:

- by Unum; or
- by the Policyholder.

Unum may cancel or modify the policy or a plan if:

- the Policyholder does not promptly provide Unum with information that is reasonably required;
- the Policyholder fails to perform any of its obligations that relate to the policy;
- fewer than 10 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of the policy that specify whether the Policyholder, the employee, or both, pay(s) the premiums;
- the Policyholder does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its employees; or
- the Policyholder paid group Life policy, or group Life and Accidental Death and Dismemberment policy, issued by Unum to the Policyholder terminates.

If Unum cancels or modifies the policy or a plan, for any reasons listed above, a written notice will be delivered to the Policyholder at least 31 days prior to the cancellation date or modification date. The Policyholder may cancel the policy or a plan if the modifications are unacceptable.

If any premium is not paid during the 31 day grace period, the policy or plan will terminate automatically at the end of the grace period. The Policyholder is liable for premium for coverage during the grace period. The Policyholder must pay Unum all premium due for the full period the policy is in force. In the event of termination, the policy or plan may be reinstated only as agreed upon by Unum and the Policyholder. If Unum agrees to reinstate the policy or plan, such reinstatement will not constitute waiver of the termination provision in the future.

The Policyholder may cancel the policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Policyholder and Unum agree, the policy or a plan can be cancelled on an earlier date. If Unum or the Policyholder cancels the policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.
If the policy or a plan is cancelled, the cancellation will not affect a payable claim.

The effective date of this amendment is October 1, 2015.
The policy's terms and provisions will apply other than as stated in this amendment.
Dated at Portland, Maine on October 1, 2015.

Unum Life Insurance Company of America

By______________________________

Secretary
Unum's Commitment to Privacy

Unum understands your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

Collecting Information
We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations, and service providers.

Sharing Information
We share the types of NPI described above primarily with people who perform insurance, business, and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

Safeguarding Information
We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.
Access to Information
You may request access to certain NPI we collect to provide you with insurance
products and services. You must make your request in writing and send it to the
address below. The letter should include your full name, address, telephone number
and policy number if we have issued a policy. If you request, we will send copies of the
NPI to you. If the NPI includes health information, we may provide the health
information to you through a health care provider you designate. We will also send you
information related to disclosures. We may charge a reasonable fee to cover our
copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to
NPI we collect in anticipation of a claim or civil or criminal proceeding.

Correction of Information
If you believe NPI we have about you is incorrect, please write to us. Your letter should
include your full name, address, telephone number and policy number if we have issued
a policy. Your letter should also explain why you believe the NPI is inaccurate. If we
agree with you, we will correct the NPI and notify you of the correction. We will also
notify any person who may have received the incorrect NPI from us in the past two
years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will
give you the reason(s) for our refusal. We will also tell you that you may submit a
statement to us. Your statement should include the NPI you believe is correct. It should
also include the reason(s) why you disagree with our decision not to correct the NPI in
our files. We will file your statement with the disputed NPI. We will include your
statement any time we disclose the disputed NPI. We will also give the statement to any
person designated by you if we may have disclosed the disputed NPI to that person in
the past two years.

Coverage Decisions
If we decide not to issue coverage to you, we will provide you with the specific reason(s)
for our decision. We will also tell you how to access and correct certain NPI.

Contacting Us
For additional information about Unum's commitment to privacy and to view a copy of
our HIPAA Privacy Notice, please visit www.unum.com/privacy or www.coloniallife.com
or write to: Privacy Officer, Unum, 2211 Congress Street, C476, Portland, Maine 04122.
We reserve the right to modify this notice. We will provide you with a new notice if we
make material changes to our privacy practices.

Unum is providing this notice to you on behalf of the following insuring companies: Unum Life Insurance
Company of America, First Unum Life Insurance Company, Provident Life and Accident Insurance
Company, Provident Life and Casualty Insurance Company, Colonial Life & Accident Insurance
Company, The Paul Revere Life Insurance Company and The Paul Revere Variable Annuity Insurance
Company.

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

MK-1883 (2-11)
APPENDIX I

LONG-TERM DISABILITY PLAN
POLICYHOLDER: The President and Fellows of Middlebury College

POLICY NUMBER: 469869 002

POLICY EFFECTIVE DATE: October 1, 2015

POLICY ANNIVERSARY DATE: January 1

GOVERNING JURISDICTION: Vermont

Unum Life Insurance Company of America (referred to as Unum) will provide benefits under this policy. Unum makes this promise subject to all of this policy's provisions.

The policyholder should read this policy carefully and contact Unum promptly with any questions. This policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. This policy consists of:

- all policy provisions and any amendments and/or attachments issued;
- employees' signed applications; and
- the certificate of coverage.

This policy may be changed in whole or in part. Only an officer or a registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to this policy. No other person, including an agent, may change this policy or waive any part of it.

Signed for Unum at Portland, Maine on the Policy Effective Date.

President

Secretary

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
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BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER’S ORIGINAL PLAN

EFFECTIVE DATE: October 1, 2015

POLICY NUMBER: 469869 002

ELIGIBLE GROUP(S):

All Full-Time Employees in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Staff Employees
Employees who are working at least 1000 hours or more per year.

Faculty Employees
Employees who are actively working for the policyholder teaching .5 FTE’s (full time equivalents) or more per year.

Faculty Employees who are appointed to an Administrative Assignment
Employees who are actively working for the policyholder at least .5 FTE’s (full-time equivalents) or more per year.

WAITING PERIOD:

For employees in an eligible group on or before October 1, 2015: None

For employees entering an eligible group after October 1, 2015: First of the month coincident with or next following the date you enter an eligible group

REHIRE:

If your employment ends and you are rehired within 90 days, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

180 days

Benefits begin the day after the elimination period is completed.

MONTHLY BENEFIT:

60% of monthly earnings to a maximum benefit of $10,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

MAXIMUM PERIOD OF PAYMENT:

<table>
<thead>
<tr>
<th>Age at Disability</th>
<th>Maximum Period of Payment</th>
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<tbody>
<tr>
<td>59 or less</td>
<td>To Social Security Normal Retirement Age</td>
</tr>
</tbody>
</table>
60 through 64  To Social Security Normal Retirement Age or 5 years, whichever is longer
65 through 69  To age 70, but not less than 1 year
70 or over  1 year

Year of Birth  Social Security Normal Retirement Age
1937 or before  65 years
1938  65 years 2 months
1939  65 years 4 months
1940  65 years 6 months
1941  65 years 8 months
1942  65 years 10 months
1943 - 1954  66 years
1955  66 years 2 months
1956  66 years 4 months
1957  66 years 6 months
1958  66 years 8 months
1959  66 years 10 months
1960 and after  67 years

No premium payments are required for your coverage while you are receiving payments under this plan.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $1,000 per month.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

DEPENDENT CARE EXPENSE BENEFIT:

While you are participating in Unum’s Rehabilitation and Return to Work Assistance program, you may receive payments to cover certain dependent care expenses limited to the following amounts:

Dependent Care Expense Benefit Amount: $350 per month, per dependent

Dependent Care Expense Maximum Benefit Amount: $1,000 per month for all eligible dependent care expenses combined

TOTAL BENEFIT CAP:

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings, unless the excess amount is payable as a Cost of Living Adjustment. However, if you are participating in Unum’s Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings, unless the excess amount is payable as a Cost of Living Adjustment.

OTHER FEATURES:

Continuity of Coverage
Conversion
Cost of Living Adjustment
Minimum Benefit
Pre-Existing: 30/5
Retirement Income Protection
Survivor Benefit
Work Life Assistance Program

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.
CLAIM INFORMATION
LONG TERM DISABILITY

WHEN DO YOU NOTIFY UNUM OF A CLAIM?

We encourage you to notify us of your claim as soon as possible, so that a claim decision can be made in a timely manner. Written notice of a claim should be sent within 30 days after the date your disability begins. However, you must send Unum written proof of your claim no later than 90 days after your elimination period. If it is not possible to give proof within 90 days, it must be given no later than 1 year after the time proof is otherwise required except in the absence of legal capacity.

The claim form is available from your Employer, or you can request a claim form from us. If you do not receive the form from Unum within 15 days of your request, send Unum written proof of claim without waiting for the form.

You must notify us immediately when you return to work in any capacity.

HOW DO YOU FILE A CLAIM?

You and your Employer must fill out your own sections of the claim form and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to Unum.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Your proof of claim, provided at your expense, must show:

- that you are under the regular care of a physician;
- the appropriate documentation of your monthly earnings;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
- the name and address of any hospital or institution where you received treatment, including all attending physicians.

We may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by us.

In some cases, you will be required to give Unum authorization to obtain additional medical information and to provide non-medical information as part of your proof of claim, or proof of continuing disability. Unum will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

TO WHOM WILL UNUM MAKE PAYMENTS?

Unum will make payments to you.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:
- fraud;
- any error Unum makes in processing a claim; and
- your receipt of deductible sources of income.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.
POLICYHOLDER PROVISIONS

WHAT IS THE COST OF THIS INSURANCE?

LONG TERM DISABILITY

The initial premium for each plan is based on the initial rate(s) shown in the Rate Information Amendment(s).

WAIVER OF PREMIUM

Unum does not require premium payments for an insured while he or she is receiving Long Term Disability payments under this plan.

INITIAL RATE GUARANTEE AND RATE CHANGES

Refer to the Rate Information Amendment(s).

WHEN IS PREMIUM DUE FOR THIS POLICY?

Premium Due Dates: Premium due dates are based on the Premium Due Dates shown in the Rate Information Amendment(s).

The Policyholder must send all premiums to Unum on or before their respective due date. The premium must be paid in United States dollars.

WHEN ARE INCREASES OR DECREASES IN PREMIUM DUE?

Premium increases or decreases which take effect during a policy month are adjusted and due on the next premium due date following the change. Changes will not be pro-rated daily.

If premiums are paid on other than a monthly basis, premiums for increases and decreases will result in a monthly pro-rated adjustment on the next premium due date.

Unum will only adjust premium for the current policy year and the prior policy year. In the case of fraud, premium adjustments will be made for all policy years.

WHAT INFORMATION DOES UNUM REQUIRE FROM THE POLICYHOLDER?

The Policyholder must provide Unum with the following on a regular basis:

- information about employees:
  - who are eligible to become insured;
  - whose amounts of coverage change; and/or
  - whose coverage ends;
- occupational information and any other information that may be required to manage a claim; and
- any other information that may be reasonably required.

Policyholder records that, in Unum's opinion, have a bearing on this policy will be available for review by Unum at any reasonable time.
Clerical error or omission by Unum will not:

- prevent an employee from receiving coverage;
- affect the amount of an insured's coverage; or
- cause an employee’s coverage to begin or continue when the coverage would not otherwise be effective.

**WHO CAN CANCEL OR MODIFY THIS POLICY OR A PLAN UNDER THIS POLICY?**

This policy or a plan under this policy can be cancelled:

- by Unum; or
- by the Policyholder.

Unum may cancel or modify this policy or a plan if:

- there is less than 75% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for a Policyholder paid plan;
- the Policyholder does not promptly provide Unum with information that is reasonably required;
- the Policyholder fails to perform any of its obligations that relate to this policy;
- fewer than 10 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of this policy that specify whether the Policyholder, the employee, or both, pay(s) the premiums;
- the Policyholder does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Policyholder and/or its employees; or
- the Policyholder fails to pay any portion of the premium within the 31 day grace period.

If Unum cancels or modifies this policy or a plan for reasons other than the Policyholder’s failure to pay premium, a written notice will be delivered to the Policyholder at least 31 days prior to the cancellation date or modification date. The Policyholder may cancel this policy or a plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or plan automatically at the end of the grace period. The Policyholder is liable for premium for coverage during the grace period. The Policyholder must pay Unum all premium due for the full period each plan is in force.

The Policyholder may cancel this policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Policyholder and Unum agree, this policy or a plan can be cancelled on an earlier date. If Unum or the Policyholder cancels this policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If this policy or a plan is cancelled, the cancellation will not affect a payable claim.
WHAT HAPPENS TO AN EMPLOYEE’S COVERAGE UNDER THIS POLICY WHILE HE OR SHE IS ON A FAMILY AND MEDICAL LEAVE OF ABSENCE?

We will continue the employee's coverage in accordance with the policyholder's Human Resource policy on family and medical leaves of absence if premium payments continue and the policyholder approved the employee's leave in writing.

Coverage will be continued until the end of the later of:

1. the leave period required by the federal Family and Medical Leave Act of 1993 and any amendments; or
2. the leave period required by applicable state law.

If the policyholder's Human Resource policy doesn't provide for continuation of an employee's coverage during a family and medical leave of absence, the employee's coverage will be reinstated when he or she returns to active employment.

We will not:

- apply a new waiting period;
- apply a new pre-existing conditions exclusion; or
- require evidence of insurability.

DIVISIONS, SUBSIDIARIES OR AFFILIATED COMPANIES INCLUDE:

NAME/LOCATION (CITY AND STATE)

The Middlebury Institute of International Studies at Monterey
Middlebury, Vermont
CERTIFICATE SECTION

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum’s claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the policy (issued to the policyholder), the policy will govern. Your coverage may be cancelled or changed in whole or in part under the terms and provisions of the policy.

The policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group policy, all days begin at 12:01 a.m. and end at 12:00 midnight at the Policyholder’s address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

If you are working for your Employer in an eligible group, the date you are eligible for coverage is the later of:

- the plan effective date; or
- the day after you complete your waiting period.

WHEN DOES YOUR COVERAGE BEGIN?

When your Employer pays 100% of the cost of your coverage under a plan, you will be covered at 12:01 a.m. on the date you are eligible for coverage.

When you and your Employer share the cost of your coverage under a plan or when you pay 100% of the cost yourself, you will be covered at 12:01 a.m. on the latest of:

- the date you are eligible for coverage, if you apply for insurance on or before that date;
- the date you apply for insurance, if you apply within 31 days after your eligibility date; or
- the date Unum approves your application, if evidence of insurability is required.

Evidence of insurability is required if you:

- are a late applicant, which means you apply for coverage more than 31 days after the date you are eligible for coverage; or
- voluntarily cancelled your coverage and are reapplying.

An evidence of insurability form can be obtained from your Employer.

WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?

If you are absent from work due to injury, sickness, temporary layoff or leave of absence, your coverage will begin on the date you return to active employment.

ONCE YOUR COVERAGE BEGINS, WHAT HAPPENS IF YOU ARE TEMPORARILY NOT WORKING?

If you are on a temporary layoff, and if premium is paid, you will be covered through the end of the month that immediately follows 60 days from the date your temporary layoff begins.
If you are on a parental leave of absence, and if premium is paid, you will be covered in accordance with your Employer's policy on leaves of absence.

If you are on any other leave of absence, and if premium is paid, you will be covered for up to 12 months following the date your leave of absence begins.

WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?

Once your coverage begins, any increased or additional coverage will take effect immediately if you are in active employment or if you are on a covered layoff or leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage will begin on the date you return to active employment.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

WHEN DOES YOUR COVERAGE END?

Your coverage under the policy or a plan ends on the earliest of:

- the date the policy or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered;
- the last day of the period for which you made any required contributions; or
- the last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim which occurs while you are covered under the policy or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You can start legal action regarding your claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any statements you or your Employer make in a signed application for coverage a representation and not a warranty. If any of the statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

We will use only statements made in a signed application as a basis for doing this.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

**HOW WILL UNUM HANDLE INSURANCE FRAUD?**

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

**DOES THE POLICY REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?**

The policy does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

**DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?**

For purposes of the policy, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.
LONG TERM DISABILITY

BENEFIT INFORMATION

HOW DOES UNUM DEFINE DISABILITY?

You are disabled when Unum determines that:

- you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
- you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.

After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

We may require you to be examined by a physician, other medical practitioner and/or vocational expert of our choice. Unum will pay for this examination. We can require an examination as often as it is reasonable to do so. We may also require you to be interviewed by an authorized Unum Representative.

HOW LONG MUST YOU BE DISABLED BEFORE YOU ARE ELIGIBLE TO RECEIVE BENEFITS?

Your elimination period is 180 days.

You are not required to have a 20% or more loss in your indexed monthly earnings due to the same injury or sickness to be considered disabled during the elimination period.

CAN YOU SATISFY YOUR ELIMINATION PERIOD IF YOU ARE WORKING?

Yes. If you are working while you are disabled, the days you are disabled will count toward your elimination period.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive payments when we approve your claim, providing the elimination period has been met and you are disabled. We will send you a payment monthly for any period for which Unum is liable.

HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED?

We will follow this process to figure your payment:

1. Multiply your monthly earnings by 60%.
2. The maximum monthly benefit is $10,000.
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your **gross disability payment**.

4. Subtract from your gross disability payment any **deductible sources of income**.

The amount figured in Item 4 is your **monthly payment**.

**WILL UNUM EVER PAY MORE THAN 100% OF MONTHLY EARNINGS?**

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings, unless the excess amount is payable as a Cost of Living Adjustment. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings, unless the excess amount is payable as a Cost of Living Adjustment.

**WHAT ARE YOUR MONTHLY EARNINGS?**

**Annual contract and Salaried Employees**

"Monthly Earnings" means 1/12th of your annual contract salary in effect just prior to your date of disability. Annual is your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

**Hourly Employees**

"Monthly Earnings" means your gross monthly income from your Employer in effect just prior to your date of disability. It is figured by multiplying the current hourly rate of pay multiplied by the number of hours you are regularly scheduled to work per month, but not more than 173.33 hours.

If you do not have regular work hours, "Monthly Earnings" will be averaged for the lesser of:

a. the 12 calendar month period of your employment with your Employer just prior to the date disability begins; or

b. the period of actual employment with your Employer

Average hours will not be more than 173.33 hours per month

It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer.

**Employees Participating in the Employer's Phased Retirement Policy**

"Monthly Earnings" is gross monthly income from your Employer in effect just prior to the date you enter the Phased Retirement Agreement with your Employer. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It is also prior to any elective pre-tax contributions to your
Employer's Nonqualified Deferred Compensation Plan. It does not include income received from commissions, bonuses, overtime pay, shift differential or any extra compensation, or income from sources other than your Employer.

**WHAT WILL WE USE FOR MONTHLY EARNINGS IF YOU BECOME DISABLED DURING A COVERED LAYOFF OR LEAVE OF ABSENCE?**

If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

**HOW MUCH WILL UNUM PAY YOU IF YOU ARE DISABLED AND WORKING?**

We will send you the monthly payment if you are disabled and your monthly disability earnings, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are 20% or more of your indexed monthly earnings, due to the same sickness or injury, Unum will figure your payment as follows:

Your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.
2. Compare the answer in Item 1 to your indexed monthly earnings.

If the answer from Item 1 is less than or equal to 100% of your indexed monthly earnings, Unum will not further reduce your monthly payment.

If the answer from Item 1 is more than 100% of your indexed monthly earnings, Unum will subtract the amount over 100% from your monthly payment.

Unum may require you to send proof of your monthly disability earnings at least quarterly. We will adjust your payment based on your quarterly disability earnings.

As part of your proof of disability earnings, we can require that you send us appropriate financial records which we believe are necessary to substantiate your income.

After the elimination period, if you are disabled for less than 1 month, we will send you 1/30 of your payment for each day of disability.

**WILL YOUR PAYMENT BE ADJUSTED BY A COST OF LIVING INCREASE?**

Unum will make a cost of living adjustment (COLA) after you have received 1 full year of payments for your disability.

Your payment will increase by 3% beginning on the first anniversary of payments and each following anniversary while you continue to receive payments for your disability.
Each month Unum will add the cost of living adjustment to your monthly payment. When Unum adds the adjustment to your payment, the increase may cause your payment to exceed the maximum monthly benefit.

**HOW CAN WE PROTECT YOU IF YOUR DISABILITY EARNINGS FLUCTUATE?**

If your disability earnings routinely fluctuate widely from month to month, Unum may average your disability earnings over the most recent 3 months to determine if your claim should continue.

If Unum averages your disability earnings, we will not terminate your claim unless:

- During the first 24 months of disability payments, the average of your disability earnings from the last 3 months exceeds 80% of indexed monthly earnings; or
- Beyond 24 months of disability payments, the average of your disability earnings from the last 3 months exceeds the gross disability payment.

We will not pay you for any month during which disability earnings exceed the amount allowable under the plan.

**WHAT ARE DEDUCTIBLE SOURCES OF INCOME?**

Unum will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive under:
   - a workers' compensation law.
   - an occupational disease law.
   - any other act or law with similar intent.

2. The amount that you receive or are entitled to receive as disability income payments under any:
   - state compulsory benefit act or law.
   - automobile liability insurance policy.
   - other group insurance plan.
   - governmental retirement system as a result of your job with your Employer.

3. The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:
   - the United States Social Security Act.
   - the Canada Pension Plan.
   - the Quebec Pension Plan.
   - any similar plan or act.

4. The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under:
   - the United States Social Security Act.
   - the Canada Pension Plan.
   - the Quebec Pension Plan.
- any similar plan or act.

5. The amount that you:

- receive as disability payments under your Employer's retirement plan.
- voluntarily elect to receive as retirement payments under your Employer's retirement plan.
- receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in your Employer's retirement plan.

Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

Retirement payments will be those benefits which are based on your Employer's contribution to the retirement plan. Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your Employer's contributions to be distributed simultaneously throughout your lifetime.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Unum will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.

6. The amount that you receive under Title 46, United States Code Section 688 (The Jones Act).

7. The amount that you receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

With the exception of retirement payments, Unum will only subtract deductible sources of income which are payable as a result of the same disability.

We will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.

**WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?**

Unum will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(a) and 403(b) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- salary continuation or accumulated sick leave plans

WHAT IF SUBTRACTING DEDUCTIBLE SOURCES OF INCOME RESULTS IN A ZERO BENEFIT? (Minimum Benefit)

The minimum monthly payment is the greater of:

- $100; or
- 10% of your gross disability payment.

Unum may apply this amount toward an outstanding overpayment.

WHAT HAPPENS WHEN YOU RECEIVE A COST OF LIVING INCREASE FROM DEDUCTIBLE SOURCES OF INCOME?

Once Unum has subtracted any deductible source of income from your gross disability payment, Unum will not further reduce your payment due to a cost of living increase from that source.

WHAT IF UNUM DETERMINES YOU MAY QUALIFY FOR DEDUCTIBLE INCOME BENEFITS?

When we determine that you may qualify for benefits under Item(s) 1, 2 and 3 in the deductible sources of income section, we will estimate your entitlement to these benefits. We can reduce your payment by the estimated amounts if such benefits:

- have not been awarded; and
- have not been denied; or
- have been denied and the denial is being appealed.

Your Long Term Disability payment will NOT be reduced by the estimated amount if you:

- apply for the disability payments under Item(s) 1, 2 and 3 in the deductible sources of income section and appeal your denial to all administrative levels Unum feels are necessary; and
- sign Unum’s payment option form. This form states that you promise to pay us any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits have been denied and all appeals Unum feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive a lump sum payment from any deductible sources of income, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, we will use a reasonable one.
HOW LONG WILL UNUM CONTINUE TO SEND YOU PAYMENTS?

Unum will send you a payment each month up to the **maximum period of payment**. Your maximum period of payment is based on your age at disability as follows:

<table>
<thead>
<tr>
<th>Age at Disability</th>
<th>Maximum Period of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>59 or less</td>
<td>To Social Security Normal Retirement Age</td>
</tr>
<tr>
<td>60 through 64</td>
<td>To Social Security Normal Retirement Age or 5 years, whichever is longer</td>
</tr>
<tr>
<td>65 through 69</td>
<td>To age 70, but not less than 1 year</td>
</tr>
<tr>
<td>70 or over</td>
<td>1 year</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Year of Birth</th>
<th>Social Security Normal Retirement Age</th>
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</thead>
<tbody>
<tr>
<td>1937 or before</td>
<td>65 years</td>
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<tr>
<td>1938</td>
<td>65 years 2 months</td>
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<tr>
<td>1939</td>
<td>65 years 4 months</td>
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<tr>
<td>1958</td>
<td>66 years 8 months</td>
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<tr>
<td>1959</td>
<td>66 years 10 months</td>
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<tr>
<td>1960 and after</td>
<td>67 years</td>
</tr>
</tbody>
</table>

WHEN WILL PAYMENTS STOP?

We will stop sending you payments and your claim will end on the earliest of the following:

- during the first 24 months of payments, when you are able to work in your regular occupation on a **part-time basis** but you do not;
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you do not;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan, unless you are eligible to receive benefits under Unum's Rehabilitation and Return to Work Assistance program;
- the date you fail to submit proof of continuing disability;
- after 12 months of payments if you are considered to reside outside the United States or Canada. You will be considered to reside outside these countries when you have been outside the United States or Canada for a total period of 6 months or more during any 12 consecutive months of benefits;
- the date your disability earnings exceed the amount allowable under the plan;
- the date you die.

WHAT DISABILITIES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:
- intentionally self-inflicted injuries.
- active participation in a riot.
- loss of a professional license, occupational license or certification.
- commission of a crime for which you have been convicted.
- pre-existing condition.

Your plan will not cover a disability due to war, declared or undeclared, or any act of war.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

**WHAT IS A PRE-EXISTING CONDITION?**

You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 30 days just prior to your effective date of coverage; and
- you have performed the material and substantial duties of your regular occupation for less than 5 consecutive days after your effective date of coverage.

**WHAT HAPPENS IF YOU RETURN TO WORK FULL TIME WITH THE POLICYHOLDER AND YOUR DISABILITY OCCURS AGAIN?**

If you have a recurrent disability, Unum will treat your disability as part of your prior claim and you will not have to complete another elimination period if:

- you were continuously insured under the plan for the period between the end of your prior claim and your recurrent disability; and
- your recurrent disability occurs within 6 months from the end of your prior claim.

Your recurrent disability will be subject to the same terms of the plan as your prior claim and will be treated as a continuation of that disability.

Any disability which occurs after 6 months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the elimination period.

If you become entitled to payments under any other group long term disability plan, you will not be eligible for payments under the Unum plan.
LONG TERM DISABILITY

OTHER BENEFIT FEATURES

WHAT BENEFITS WILL BE PROVIDED TO YOU OR YOUR FAMILY IF YOU DIE OR ARE TERMINALLY ILL? (Survivor Benefit)

When Unum receives proof that you have died, we will pay your eligible survivor a lump sum benefit equal to 3 months of your gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the survivor benefit to any overpayment which may exist on your claim.

You may receive your 3 month survivor benefit prior to your death if you have been diagnosed as terminally ill.

We will pay you a lump sum amount equal to 3 months of your gross disability payment if:

- you have been diagnosed with a terminal illness or condition;
- your life expectancy has been reduced to less than 12 months; and
- you are receiving monthly payments.

Your right to exercise this option and receive payment is subject to the following:

- you must make this election in writing to Unum; and
- your physician must certify in writing that you have a terminal illness or condition and your life expectancy has been reduced to less than 12 months.

This benefit is available to you on a voluntary basis and will only be payable once.

If you elect to receive this benefit prior to your death, no 3 month survivor benefit will be payable upon your death.

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

When the plan becomes effective, Unum will provide coverage for you if:

- you are not in active employment because of a sickness or injury; and
- you were covered by the prior policy.

Your coverage is subject to payment of premium.

Your payment will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which your prior carrier is liable.
WHAT IF YOU HAVE A DISABILITY DUE TO A PRE-EXISTING CONDITION WHEN YOUR EMPLOYER CHANGES INSURANCE CARRIERS TO UNUM? (Continuity of Coverage)

Unum may send a payment if your disability results from a pre-existing condition if, you were:

- in active employment and insured under the plan on its effective date; and
- insured by the prior policy at the time of change.

In order to receive a payment you must satisfy the pre-existing condition provision under:

1. the Unum plan; or  
2. the prior carrier's plan, if benefits would have been paid had that policy remained in force.

If you do not satisfy Item 1 or 2 above, Unum will not make any payments.

If you satisfy Item 1, we will determine your payments according to the Unum plan provisions.

If you only satisfy Item 2, we will administer your claim according to the Unum plan provisions. However, your payment will be the lesser of:

a. the monthly benefit that would have been payable under the terms of the prior plan if it had remained in force; or  
b. the monthly payment under the Unum plan.

Your benefits will end on the earlier of the following dates:

1. the end of the maximum benefit period under the plan; or  
2. the date benefits would have ended under the prior plan if it had remained in force.

WHAT INSURANCE IS AVAILABLE IF YOU END EMPLOYMENT? (Conversion)

If you end employment with your Employer, your coverage under the plan will end. You may be eligible to purchase insurance under Unum’s group conversion policy. To be eligible, you must have been insured under your Employer's group plan for at least 12 consecutive months. We will consider the amount of time you were insured under the Unum plan and the plan it replaced, if any.

You must apply for insurance under the conversion policy and pay the first quarterly premium within 31 days after the date your employment ends.

Unum will determine the coverage you will have under the conversion policy. The conversion policy may not be the same coverage we offered you under your Employer's group plan.

You are not eligible to apply for coverage under Unum's group conversion policy if:
- you are or become insured under another group long term disability plan within 31 days after your employment ends;
- you are disabled under the terms of the plan;
- you recover from a disability and do not return to work for your Employer;
- you are on a leave of absence; or
- your coverage under the plan ends for any of the following reasons:
  • the plan is cancelled;
  • the plan is changed to exclude the group of employees to which you belong;
  • you are no longer in an eligible group;
  • you end your working career or retire and receive payment from any Employer's retirement plan; or
  • you fail to pay the required premium under this plan.

**WILL UNUM CONTINUE YOUR CONTRIBUTION TO YOUR PENSION PLAN IF YOU ARE DISABLED? (Retirement Income Protection)**

If you are receiving disability payments and have been a participant in the pension plan for at least 3 months prior to your disability, we will pay your Employer an extra benefit to be deposited into the plan on your behalf.

We will pay your Employer 15% of your monthly earnings, not to exceed the maximum allowable by law.

If you are disabled and working and your monthly disability earnings are 20% or more of your indexed monthly earnings, the benefit will be based on the percentage of income you are losing due to your disability according to the following steps.

1. Subtract your disability earnings from your indexed monthly earnings;
2. Divide the answer in Step 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your extra monthly benefit by the percentage of lost earnings calculated in Step 2.

This is the amount payable to your Employer for contribution into your Pension plan or, if the plan can not accept contributions for you, into a flexible premium deferred annuity that is established and maintained by you.

During the first 24 months of disability payments, if your monthly disability earnings exceed 80% of your indexed monthly earnings, Unum will stop sending you payments and your claim will end.

Beyond 24 months of disability payments, if your monthly disability earnings exceed the gross disability payment, Unum will stop sending you payments and your claim will end.

**HOW CAN UNUM’S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM HELP YOU RETURN TO WORK?**

Unum has a vocational Rehabilitation and Return to Work Assistance program available to assist you in returning to work. We will determine whether you are eligible for this program. In order to be eligible for rehabilitation services and benefits, you must be medically able to engage in a return to work program.
Your claim file will be reviewed by one of Unum’s rehabilitation professionals to determine if a rehabilitation program might help you return to gainful employment. As your file is reviewed, medical and vocational information will be analyzed to determine an appropriate return to work program.

We will make the final determination of your eligibility for participation in the program.

We will provide you with a written Rehabilitation and Return to Work Assistance plan developed specifically for you.

The rehabilitation program may include, but is not limited to, the following services and benefits:

- coordination with your Employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training; or
- education and retraining expenses for a new occupation.

**WHAT ADDITIONAL BENEFITS WILL UNUM PAY WHILE YOU PARTICIPATE IN A REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?**

We will pay an additional disability benefit of 10% of your gross disability payment to a maximum benefit of $1,000 per month.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount such as Deductible Sources of Income. However, the Total Benefit Cap will apply.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

This benefit payment may be paid in a lump sum.

**WHEN WILL REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFITS END?**

Benefits for the Rehabilitation and Return to Work Assistance program will end on the earliest of the following dates:

- the date Unum determines that you are no longer eligible to participate in Unum’s Rehabilitation and Return to Work Assistance program; or
- any other date on which monthly payments would stop in accordance with this plan.

LTD-OTR-4 (10/1/2015)
**WHAT ADDITIONAL BENEFIT IS AVAILABLE FOR DEPENDENT CARE EXPENSES TO ENABLE YOU TO PARTICIPATE IN UNUM’S REHABILITATION AND RETURN TO WORK ASSISTANCE PROGRAM?**

While you are participating in Unum’s Rehabilitation and Return to Work Assistance program, we will pay a Dependent Care Expense Benefit when you are disabled and you:

1. are incurring expenses to provide care for a child under the age of 15; and/or
2. start incurring expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.

The payment of the Dependent Care Expense Benefit will begin immediately after you start Unum's Rehabilitation and Return to Work Assistance program.

Our payment of the Dependent Care Expense Benefit will:

1. be $350 per month, per dependent; and
2. not exceed $1,000 per month for all dependent care expenses combined.

To receive this benefit, you must provide satisfactory proof that you are incurring expenses that entitle you to the Dependent Care Expense Benefit.

Dependent Care Expense Benefits will end on the earlier of the following:

1. the date you are no longer incurring expenses for your dependent;
2. the date you no longer participate in Unum’s Rehabilitation and Return to Work Assistance program; or
3. any other date payments would stop in accordance with this plan.
OTHER SERVICES

These services are also available from us as part of your Unum Long Term Disability plan.

IS THERE A WORK LIFE ASSISTANCE PROGRAM AVAILABLE WITH THE PLAN?

We do provide you and your dependents access to a work life assistance program designed to assist you with problems of daily living.

You can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a child, to helping to deal with the stress of the workplace. This work life program is available for everyday issues as well as crisis support.

This service is also available to your Employer.

This program can be accessed by a 1-800 telephone number available 24 hours a day, 7 days a week or online through a website.

Information about this program can be obtained through your plan administrator.

HOW CAN UNUM HELP YOUR EMPLOYER IDENTIFY AND PROVIDE WORKSITE MODIFICATION?

A worksite modification might be what is needed to allow you to perform the material and substantial duties of your regular occupation with your Employer. One of our designated professionals will assist you and your Employer to identify a modification we agree is likely to help you remain at work or return to work. This agreement will be in writing and must be signed by you, your Employer and Unum.

When this occurs, Unum will reimburse your Employer for the cost of the modification, up to the greater of:

- $1,000; or
- the equivalent of 2 months of your monthly benefit.

This benefit is available to you on a one time only basis.

HOW CAN UNUM’S SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM ASSIST YOU WITH OBTAINING SOCIAL SECURITY DISABILITY BENEFITS?

In order to be eligible for assistance from Unum's Social Security claimant advocacy program, you must be receiving monthly payments from us. Unum can provide expert advice regarding your claim and assist you with your application or appeal.

Receiving Social Security benefits may enable:

- you to receive Medicare after 24 months of disability payments;
- you to protect your retirement benefits; and
- your family to be eligible for Social Security benefits.

We can assist you in obtaining Social Security disability benefits by:
- helping you find appropriate legal representation;
- obtaining medical and vocational evidence; and
- reimbursing pre-approved case management expenses.
GLOSSARY

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and that you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s) in each plan.

Your work site must be:

- your Employer's usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
- a location to which your job requires you to travel.

Normal vacation is considered active employment. Temporary and seasonal workers are excluded from coverage.

DEDUCTIBLE SOURCES OF INCOME means income from deductible sources listed in the plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

DEPENDENT means:

- your child(ren) under the age of 15; and
- your child(ren) age 15 or over or a family member who requires personal care assistance.

DISABILITY EARNINGS means the earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your maximum capacity.

ELIMINATION PERIOD means a period of continuous disability which must be satisfied before you are eligible to receive benefits from Unum.

EMPLOYEE means a person who is in active employment in the United States with the Employer.

EMPLOYER means the Policyholder, and includes any division, subsidiary or affiliated company named in the policy.

EVIDENCE OF INSURABILITY means a statement of your medical history which Unum will use to determine if you are approved for coverage. Evidence of insurability will be at Unum's expense.

GAINFUL OCCUPATION means an occupation that is or can be expected to provide you with an income at least equal to your gross disability payment within 12 months of your return to work.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

GROSS DISABILITY PAYMENT means the benefit amount before Unum subtracts deductible sources of income and disability earnings.
**HOSPITAL OR INSTITUTION** means an accredited facility licensed to provide care and treatment for the condition causing your disability.

**INDEXED MONTHLY EARNINGS** means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same, but will never decrease.

The Consumer Price Index (CPI-U) is published by the U.S. Department of Labor. Unum reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U.

Indexing is only used as a factor in the determination of the percentage of lost earnings while you are disabled and working and in the determination of gainful occupation.

**INJURY** means a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

**INSURED** means any person covered under a plan.

**LAW, PLAN OR ACT** means the original enactments of the law, plan or act and all amendments.

**LAYOFF** or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer.

Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

**LIMITED** means what you cannot or are unable to do.

**MATERIAL AND SUBSTANTIAL DUTIES** means duties that:
- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified, except that if you are required to work on average in excess of 40 hours per week, Unum will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

**MAXIMUM CAPACITY** means, based on your restrictions and limitations:
- during the first 24 months of disability, the greatest extent of work you are able to do in your regular occupation, that is reasonably available.
- beyond 24 months of disability, the greatest extent of work you are able to do in any occupation, that is reasonably available, for which you are reasonably fitted by education, training or experience.

**MAXIMUM PERIOD OF PAYMENT** means the longest period of time Unum will make payments to you for any one period of disability.

**MONTHLY BENEFIT** means the total benefit amount for which an employee is insured under this plan subject to the maximum benefit.
MONTHLY EARNINGS means your gross monthly income from your Employer as defined in the plan.

MONTHLY PAYMENT means your payment after any deductible sources of income have been subtracted from your gross disability payment.

PART-TIME BASIS means the ability to work and earn 20% or more of your indexed monthly earnings.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the policy.

PENSION PLAN means a plan which provides retirement benefits and which is not wholly funded by employee contributions. The term shall not include a profit sharing plan, a thrift plan, an individual retirement account (IRA), a tax sheltered annuity (TSA), a stock ownership plan or a non-qualified plan of deferred compensation.

PHYSICIAN means:
- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

Unum will not recognize you, or your spouse, children, parents or siblings as a physician for a claim that you send to us.

PLAN means a line of coverage under the policy.

POLICYHOLDER means the Employer to whom the policy is issued.

PRE-EXISTING CONDITION means a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines for your condition during the given period of time as stated in the plan.

RECURRENT DISABILITY means a disability which is:
- caused by a worsening in your condition; and
- due to the same cause(s) as your prior disability for which Unum made a Long Term Disability payment.

REGULAR CARE means:
- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.
**REGULAR OCCUPATION** means the occupation you are routinely performing when your disability begins. Unum will look at your occupation as it is normally performed in the national economy, instead of how the work tasks are performed for a specific employer or at a specific location.

**RETIREMENT PLAN** means a defined contribution plan or defined benefit plan. These are plans which provide retirement benefits to employees and are not funded entirely by employee contributions. Retirement Plan includes but is not limited to any plan which is part of any federal, state, county, municipal or association retirement system.

**SALARY CONTINUATION OR ACCUMULATED SICK LEAVE** means continued payments to you by your Employer of all or part of your monthly earnings, after you become disabled as defined by the Policy. This continued payment must be part of an established plan maintained by your Employer for the benefit of all employees covered under the Policy. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account in calculating your monthly payment.

**SICKNESS** means an illness or disease. Disability must begin while you are covered under the plan.

**SURVIVOR, ELIGIBLE** means your spouse, if living; otherwise your children under age 25 equally.

**TOTAL COVERED PAYROLL** means the total amount of monthly earnings for which employees are insured under this plan.

**WAITING PERIOD** means the continuous period of time (shown in each plan) that you must be in active employment in an eligible group before you are eligible for coverage under a plan.


**YOU** means an employee who is eligible for Unum coverage.
VERMONT MANDATORY CIVIL UNIONS ENDORSEMENT

PURPOSE:

Vermont law requires that health and life insurers recognize parties to a civil union that is equivalent to coverage provided to married persons. This endorsement is part of and amends this policy, contract, certificate, summary of benefits and/or riders and endorsements to comply with Vermont law.

DEFINITIONS, TERMS, CONDITIONS AND PROVISIONS:

The definitions, terms, conditions and any other provisions of this policy, contract, certificate, summary of benefits and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family", "family member" and any other such terms include the relationship created by a civil union established according to Vermont law.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

Terms that mean or refer to family relationships arising from a marriage, such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor", "family member" and any other such terms include family relationships created by a civil union established according to Vermont law.

Where applicable, "dependent" means a spouse, a party to a civil union, and/or a child or children who are born to or brought to a marriage or to a civil union. Child or children include the insured's own natural offspring, lawfully adopted children and stepchildren. A child will be considered adopted on the date of placement in the insured's home. Child or children will also include an unmarried child who is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy or physical handicap and who become so incapable prior to the limiting age and who is dependent on the insured for support and maintenance.

They also may include foster children and other minor children who are dependent on the insured for main support and living with the insured in a regular parent-child relationship.

Where applicable, "child or covered child" includes:

- the insured's own natural offspring, lawfully adopted children and stepchildren. A child will be considered adopted on the date of placement in the insured's home.
- an unmarried child who is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy or physical handicap and who became so incapable prior to the limiting age and who is dependent on the insured for support and maintenance.
They also may include foster children and other minor children who are dependent on the insured for main support and living with the insured in a regular parent-child relationship.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to life and health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as "ERISA", controls the employer/employee relationship with regard to determining eligibility for enrollment in non-exempt private employer welfare benefit plans. Because of ERISA, Vermont Act 91 relating to civil unions does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide benefits to the dependents of a party to a civil union if the public employer provides benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, summary of benefits, rider or endorsement that derive from federal law. You are advised to seek expert advise to determine your rights under this policy, contract, summary of benefits, certificate, and/or riders and endorsements.
ERISA

Additional Summary Plan Description Information

If the policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the policy constitute the Plan. Benefit determinations are controlled exclusively by the policy, your certificate of coverage and the information contained in this document.

Name of Plan:
The President and Fellows of Middlebury College Plan

Name and Address of Employer:
The President and Fellows of Middlebury College  
152 Maple Street  
Suite 203 (Benefits)  
Middlebury, Vermont  
05753

Plan Identification Number:
a. Employer IRS Identification #: 03-0179298  
b. Plan #: 501

Type of Welfare Plan:  
Disability Income

Type of Administration:  
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance policy issued to the Plan.

ERISA Plan Year Ends:  
December 31

Plan Administrator, Name, Address, and Telephone Number:
The President and Fellows of Middlebury College  
152 Maple Street  
Suite 203 (Benefits)  
Middlebury, Vermont  
05753  
(802) 443-5000

The President and Fellows of Middlebury College is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:  
The President and Fellows of Middlebury College
Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

**Funding and Contributions:**
The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under policy number 469869 002. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

**EMPLOYER’S RIGHT TO AMEND THE PLAN**

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

**EMPLOYER’S RIGHT TO REQUEST POLICY CHANGE**

The Employer can request a policy change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the policy.

**MODIFYING OR CANCELLING THE POLICY OR A PLAN UNDER THE POLICY**

The policy or a plan under the policy can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the policy or a plan if:

- there is less than 75% participation of those eligible employees who pay all or part of their premium for a plan; or
- there is less than 100% participation of those eligible employees for an Employer paid plan;
- the Employer does not promptly provide Unum with information that is reasonably required;
- the Employer fails to perform any of its obligations that relate to the policy;
- fewer than 10 employees are insured under a plan;
- the premium is not paid in accordance with the provisions of the policy that specify whether the Employer, the employee, or both, pay(s) the premiums;
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group;
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or
- the Employer fails to pay any portion of the premium within the 31 day grace period.

If Unum cancels or modifies the policy or a plan for reasons other than the Employer’s failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the policy or a plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the policy or plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the policy or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the policy or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the policy or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the policy or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

Unum will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Unum both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which Unum expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

- state the specific reason(s) for the determination;
- reference specific Plan provision(s) on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe Plan procedures and time limits for appealing the determination, and your
  right to obtain information about those procedures and the right to bring a lawsuit
  under Section 502(a) of ERISA following an adverse determination from Unum on
  appeal; and

- disclose any internal rule, guidelines, protocol or similar criterion relied on in
  making the adverse determination (or state that such information will be provided
  free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic
notices will be provided in a form that complies with any applicable legal
requirements.

APPEAL PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to
file an appeal. Requests for appeals should be sent to the address specified in the
claim denial. A decision on review will be made not later than 45 days following
receipt of the written request for review. If Unum determines that special
circumstances require an extension of time for a decision on review, the review
period may be extended by an additional 45 days (90 days in total). Unum will notify
you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary
to decide the appeal, the notice of extension will specifically describe the required
information, and you will be afforded at least 45 days to provide the specified
information. If you deliver the requested information within the time specified, the 45
day extension of the appeal period will begin after you have provided that
information. If you fail to deliver the requested information within the time specified,
Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other
information in support of your appeal. You will have access to all relevant
documents as defined by applicable U.S. Department of Labor regulations. The
review of the adverse benefit determination will take into account all new
information, whether or not presented or available at the initial determination. No
deerence will be afforded to the initial determination.

The review will be conducted by Unum and will be made by a person different from
the person who made the initial determination and such person will not be the
original decision maker's subordinate. In the case of a claim denied on the grounds
of a medical judgment, Unum will consult with a health professional with appropriate
training and experience. The health care professional who is consulted on appeal
will not be the individual who was consulted during the initial determination or a
subordinate. If the advice of a medical or vocational expert was obtained by the
Plan in connection with the denial of your claim, Unum will provide you with the
names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- the specific reason(s) for the determination;

- a reference to the specific Plan provision(s) on which the determination is based;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;
- the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
- the statement that "You or your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, 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 summary plan description. 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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate 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 benefit or exercising your rights under ERISA.

**Enforce Your Rights**

If your claim for a 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 that is denied or ignored, in whole or in part, you may file suit in a state or 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, if, for example, 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, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**OTHER RIGHTS**

Unum, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of disability earnings or deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. Unum and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.
Unum's Commitment to Privacy

Unum understands your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (NPI). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

Collecting Information
We collect NPI about our customers to provide them with insurance products and services. This may include telephone number, address, date of birth, occupation, income and health history. We may receive NPI from your applications and forms, medical providers, other insurers, employers, insurance support organizations, and service providers.

Sharing Information
We share the types of NPI described above primarily with people who perform insurance, business, and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization. The organization may retain the NPI and disclose it to others for whom it performs services. In certain cases, we may share NPI with group policyholders for reporting and auditing purposes. We may share NPI with parties to a proposed or final sale of insurance business or for study purposes. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

Please be assured we do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services. For example, we do not sell your name to catalog companies.

The law allows us to share NPI as described above (except health information) with affiliates to market financial products and services. The law does not allow you to restrict these disclosures. We may also share with companies that help us market our insurance products and services, such as vendors that provide mailing services to us. We may share with other financial institutions to jointly market financial products and services. When required by law, we ask your permission before we share NPI for marketing purposes.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

Unum companies, including insurers and insurance service providers, may share NPI about you with each other. The NPI might not be directly related to our transaction or experience with you. It may include financial or other personal information such as employment history. Consistent with the Fair Credit Reporting Act, we ask your permission before sharing NPI that is not directly related to our transaction or experience with you.

Safeguarding Information
We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees who need to know the NPI to provide insurance products or services to you.
Access to Information
You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our copying costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

Correction of Information
If you believe NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two years.

Coverage Decisions
If we decide not to issue coverage to you, we will provide you with the specific reason(s) for our decision. We will also tell you how to access and correct certain NPI.

Contacting Us
For additional information about Unum's commitment to privacy and to view a copy of our HIPAA Privacy Notice, please visit www.unum.com/privacy or www.coloniallife.com or write to: Privacy Officer, Unum, 2211 Congress Street, C476, Portland, Maine 04122. We reserve the right to modify this notice. We will provide you with a new notice if we make material changes to our privacy practices.


Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

MK-1883 (2-11)
APPENDIX J

SHORT-TERM DISABILITY PLAN
Short-Term Disability Plan

Effective Date: January 1, 2017

Contact Information

Plan Administrator: The President and Fellows of Middlebury College
Address and Telephone #: Middlebury, VT 05753
(802)443-5465

Claims Administrator: UNUM
Address and Telephone #: The Benefits Center
P.O. Box 100158
Columbia, S.C. 29202-3158
Phone: 800-858-6843
Fax: 800-447-2498
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II. Overview of Plan

The short-term disability insurance benefits offered under the Plan are sponsored by your Employer, and are intended to replace a portion of your income in the event a sickness or injury prevents you from working for a period of time. This short-term disability insurance benefit does not provide benefits for occupational injuries or sicknesses. Detailed information about your eligibility for coverage, what benefits are payable, how to file a claim, and other features of the short-term disability insurance benefit are contained in this document.

The short-term disability insurance benefit is a self-funded, employer-paid benefit. The Employer has engaged UNUM to provide certain administrative claims handling services for the short-term disability insurance benefit. Neither UNUM nor any of its affiliates or related entities insure the short-term disability insurance benefits under the Plan, or has any responsibility to fund the short-term disability insurance benefits under the Plan.

The Employer is the Plan Sponsor. The Employer reserves the right to modify, amend, suspend or terminate, in whole or in part, any of the provisions of this Plan at any time for any reason or for no reason. When making a benefit determination under the Plan, the Employer has discretionary authority to determine your eligibility for benefits and to interpret and enforce the terms and provisions of the Plan. The Employer may delegate some or all of this authority to UNUM at any time.

This document is written in plain English. If you do not understand any of the terms in it, or desire more information, you should contact the Plan Administrator. Many of the terms used are defined in the Definitions Section. Be sure to read all the definitions so that you fully understand the short-term disability insurance benefits provided under the Plan.

III. Summary of Benefits

This Summary of Benefits highlights many of the features of the short-term disability insurance benefits offered under the Plan. Refer to each section for a more complete description of benefits under the Plan.

POLICYHOLDER: The President and Fellows of Middlebury College

POLICY NUMBER: 469906

ELIGIBLE GROUP(S) AND BI-WEEKLY BENEFIT AMOUNTS:
Eligible Employees of the College and MIIS, as defined in Section 2.1 of the SPD, who are in active employment on the payroll in the United States with the Employer, as described in the chart below:
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<th>Bi-Weekly Benefit Amount</th>
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<tr>
<td>Middlebury Staff and Monterey Staff NOT enrolled in CA SDI</td>
<td>Eligible</td>
<td>60% of Bi-Weekly Earnings</td>
</tr>
<tr>
<td>Middlebury Staff and Monterey Staff enrolled in CA SDI and whose earnings are above the CA SDI wage ceiling</td>
<td>Eligible</td>
<td>60% of Bi-Weekly Earnings in excess of the CA SDI wage ceiling</td>
</tr>
<tr>
<td>Monterey Faculty enrolled in CA SDI and whose earnings are below the CA SDI wage ceiling</td>
<td>Not Eligible</td>
<td>N/A</td>
</tr>
<tr>
<td>Monterey Faculty enrolled in CA SDI and whose earnings are above the CA SDI wage ceiling</td>
<td>Eligible</td>
<td>60% of Bi-Weekly Earnings in excess of the CA SDI wage ceiling (eff. 7/1/17)*</td>
</tr>
<tr>
<td>Monterey Faculty NOT enrolled in CA SDI</td>
<td>Eligible</td>
<td>60% of Bi-Weekly Earnings (eff. 7/1/17)†</td>
</tr>
<tr>
<td>Middlebury Faculty</td>
<td>Eligible</td>
<td>60% of Bi-Weekly Earnings (eff. 2/1/17)*</td>
</tr>
</tbody>
</table>

* Prior to July 1, 2017 Faculty Employees of the Middlebury Institute (MIIS) were eligible for a different level of STD benefits. See previous SPD or contact HR for details.
*† Prior to February 1, 2017 Faculty Employees of the College were eligible for other short-term salary continuation benefits, as set forth in the Faculty Handbook.

**COORDINATION WITH CA STATE DISABILITY**

MIIS Employees, whether or not eligible for this program, may be eligible for disability benefits under California’s state disability program; employees who are eligible for state disability benefit plans must apply for state benefits. The short-term disability benefits payable by this plan have been reduced to account for expected state disability benefits.

Employees who work in a state other than CA and participate in a state disability program must apply for state disability benefits. Any benefits received will be considered a deductible source of income (see section V).

**WAITING PERIOD:**

The Waiting Period for new or newly eligible employees shall end the first of the month coincident with or next following classification as an Eligible Employee.
You must be in continuous active employment as an Eligible Employee during the specified Waiting Period.

**ELIMINATION PERIOD:**

The Elimination Period shall be:

- 14 days for disability due to an injury; or
- 14 days for disability due to a sickness.

Benefits begin the day after the Elimination Period is completed.

**BI-WEEKLY BENEFIT AMOUNT:**

Please see the chart above for the applicable Bi-Weekly Benefit Amount based upon your employment classification.

Your payment may be reduced by Deductible Sources of Income and, in some cases, by the income you earn while disabled.

**BI-WEEKLY EARNINGS:**

“Bi-Weekly Earnings” generally means 1/26 of your gross annual stated salary from your Employer in effect on your date of disability and is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, shift differential or any other extra compensation, or income received from sources other than your Employer. If your gross annual stated salary is increased by the Employer during your period of disability, your Bi-Weekly Earnings will be adjusted to reflect the salary increase.

**MAXIMUM PERIOD OF PAYMENT:**

26 weeks

**OCCUPATIONAL INJURIES:**

Your short-term disability insurance benefits do not cover disabilities due to an Occupational Sickness or Injury.

**WHO PAYS FOR THE COST OF PLAN FUNDING?**

Your Employer pays the full cost of your coverage.

IV. Eligibility

**WHEN ARE YOU ELIGIBLE FOR COVERAGE?**

If you are an Eligible Employee, the date you are eligible for coverage is the later of:

- the Plan effective date; or
- the day after you complete your **Waiting Period**.

**WHEN DOES YOUR COVERAGE BEGIN?**

You will be covered at 12:01 a.m. at your Employer’s place of business on the date you are eligible for coverage.

**WHAT IF YOU ARE ABSENT FROM WORK ON THE DATE YOUR COVERAGE WOULD NORMALLY BEGIN?**

If you are absent from work due to Injury or Sickness, your coverage will begin on the date you return to Active Employment.

**WHEN WILL CHANGES TO YOUR COVERAGE TAKE EFFECT?**

Once your coverage begins, any increased or additional coverage will take effect immediately if you are in Active Employment. If you are not in Active Employment due to Injury or Sickness, any increased or additional coverage will begin on the date you return to Active Employment.

**WHEN DOES YOUR COVERAGE END?**

Your coverage under the Plan ends on the earliest of:

- the date the Plan is terminated by the Employer;
- the date you are no longer an Eligible Employee;
- the date your eligible group is no longer covered;
- the date that is two weeks plus six months from the date of disability;
- the date you begin receiving long-term disability benefits; or
- the last day you are in Active Employment.

**WHAT HAPPENS IF YOU ARE ON A LAYOFF OR LEAVE?**

If you are on a temporary **Layoff** you will be covered through the end of the month that immediately follows 60 days from the date your temporary Layoff begins.

If you are on any **Leave of Absence** you may be covered for a maximum of 12 months, as agreed by your Employer and stipulated in writing, following the date your Leave of Absence begins.

**V. Benefit Provisions**

**WHEN ARE YOU CONSIDERED DISABLED?**

You are disabled when it is determined that:

- you are limited from performing the **Material and Substantial Duties** of your **Regular Occupation** due to your **Sickness** or **Injury**; and
- you have a 20% or more loss in Bi-Weekly Earnings due to that same Sickness or Injury.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.
If you have a Cesarean section, you will be considered disabled for a minimum period of eight weeks beginning on the date of your Cesarean section, unless you return to work prior to the end of the eight weeks.

The Plan Sponsor, or its claims representative, may require you to be examined by a physician, other medical practitioner and/or vocational expert of the Plan Sponsor or its choice. This examination will be at no cost to you and can be required as often as it is reasonable to do so. The Plan Sponsor may also require you to be interviewed in person by a member of the Plan Sponsor or its representative.

WHEN WILL YOU BEGIN TO RECEIVE PAYMENTS?

You will begin to receive Bi-Weekly Payments when your claim is approved, providing the 14-day Elimination Period has been met. After the Elimination Period, if you are disabled for less than two weeks, you will receive a pro-rated portion of your payment based upon your normal work schedule.

HOW MUCH WILL YOUR BENEFIT AMOUNT BE WHEN YOU ARE DISABLED AND NOT WORKING?

The Plan will follow this process to figure your payment:

1. Multiply your Bi-Weekly Earnings by the Bi-Weekly Benefit percentage amount as stated in the Summary of Benefits.
2. Subtract from your gross disability payment any Deductible Sources of Income.

The amount figured in Item 2 is your Bi-Weekly Payment.

WHAT ARE YOUR BI-WEEKLY EARNINGS?

“Bi-Weekly Earnings” generally means your gross stated salary from your Employer in effect on your date of disability. If your gross annual stated salary is increased by the Employer during your period of disability, your Bi-Weekly Earnings will be adjusted to reflect the salary increase. See Summary of Benefits for a description of how Bi-Weekly Earnings are calculated. These will be paid out as your Bi-Weekly Payment.

WHAT WILL YOUR EMPLOYER USE FOR BI-WEEKLY EARNINGS IF YOU BECOME DISABLED DURING A LAYOFF OR LEAVE OF ABSENCE?

If you become disabled while you are on a Layoff or Leave of Absence and are covered for short-term disability insurance benefits under the Plan, your Employer will initially use your Bi-Weekly Earnings in effect on the date your absence begins.

WHAT BENEFIT WILL YOU RECEIVE IF YOU ARE WORKING AND DISABLED?

The Plan will provide you the Bi-Weekly Payment if you are disabled and your Bi-Weekly Disability Earnings, if any, are less than 20% of your Bi-Weekly Earnings.
If you are disabled and your Bi-Weekly Disability Earnings are from 20% through 80% of your Bi-Weekly Earnings, you will receive payments based on the percentage of income you are losing due to your disability. The Plan will follow this process to figure your payment:

1. Subtract your Disability Earnings from your Bi-Weekly Earnings.
2. Divide the answer in Item 1 by your Bi-Weekly Earnings. This is your percentage of lost earnings.
3. Multiply your Bi-Weekly Payment as shown above by the answer in Item 2.

This is the amount the Plan will pay you each paycheck.

The Plan may require you to send proof of your Disability Earnings each pay period. The Plan will adjust your Bi-Weekly Payment based on your Disability Earnings.

As part of your proof of Disability Earnings, you may be required to provide appropriate financial records which the Plan Sponsor believes are necessary to substantiate your income.

**WHAT ARE DEDUCTIBLE SOURCES OF INCOME?**

Payments that you receive as disability income payments are Deductible Sources of Income and will be subtracted from your gross disability payment if they are paid pursuant to or under any:

- severance or other forms of employment payments provided by an employer,
- state compulsory benefit act or law (EXCLUDING California Weekly payments under the California State Disability program),
- no fault motor vehicle plan,
- automobile liability insurance policy,
- other group insurance or benefit plan,
- from a third party (after subtracting attorney’s fees) by judgment, settlement, or otherwise,
- the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act

**WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?**

- 401(a) plans
- 403(b) plans
- tax sheltered annuities
- non-qualified plans of deferred compensation
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another Employer
- individual retirement accounts (IRA)
- individual disability income plans
- salary continuation or accumulated sick leave plans
- combined time off (CTO)
Only deductible sources of income that are payable as a result of the same disability will be subtracted from the Bi-Weekly Payment.

Disability benefits that reduce the retirement benefit under the Plan will not be subtracted from the Bi-Weekly Payment.

You must notify the Plan whenever you receive payments that are Deductible Sources of Income. You must repay the Plan for any overpayment of your claim resulting from your failure to notify the Plan in a timely manner of such income.

**HOW LONG WILL YOU RECEIVE PAYMENTS?**

You will receive a payment, assuming you continue to qualify for benefits, for up to the maximum period of payment of 26 weeks.

**WHEN WILL PAYMENTS STOP?**

The Plan will stop sending you payments and your claim will end on the earliest of the following:

- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the Plan;
- the date you fail to submit proof of continuing disability;
- the date you die;
- the date you begin receiving long-term disability benefit payments; or
- when you are able to work in your regular occupation on a part-time basis but choose not to.

**WHAT HAPPENS IF YOU RETURN TO WORK AND YOUR DISABILITY OCCURS AGAIN?**

If you return to work with your Employer as an Eligible Employee for thirty consecutive days or less, and you again become disabled, then your current disability will be treated as part of your prior claim and you will not have to complete another elimination period. If you return to work as an Eligible Employee for thirty-one or more consecutive days, your current disability will be treated as a new claim. The new claim will be subject to all of the provisions of the Plan and you will be required to satisfy a new Elimination Period.

**VI. Exclusions and Limitations**

Benefits will not be paid for any disabilities caused by, contributed to by, or resulting from your:

- occupational sickness or injury,
- intentionally self-inflicted injuries, while sane or insane,
- active participation in a riot,
- loss of a professional license, occupational license or certification,
- cosmetic surgery, except surgery made necessary by accidental injury incurred while covered under the Plan,
- commission of a crime for which you have been convicted,
- attempt to commit a crime; or
- pre-existing condition (see below).
The Plan will not cover a disability due to war, declared or undeclared, or any act of war.

The Plan will not pay a benefit for any period of disability during which you are incarcerated.

VII. Claim and Appeal Information

WHEN DO YOU NOTIFY THE PLAN OF A CLAIM?

The Plan encourages you to notify UNUM of your claim as soon as possible, so that a claim decision can be made in a timely manner. Written notice of a claim should be sent to UNUM within 30 days after the date your disability begins. In addition, you must send UNUM written proof of your claim no later than 90 days after your Elimination Period. If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required except in the absence of legal capacity.

You must notify UNUM immediately when you return to work in any capacity. Unless your Employer has given you different delivery instructions, you should use the contact information on the cover page when notifying UNUM of your claim.

HOW DO YOU FILE A CLAIM?

A claim form, which can be used as your proof of claim, is available from UNUM or from your Employer. If you do not receive the form within 15 days of your request, send UNUM written proof of claim without waiting for the form.

You must fill out the employee section of the claim form, have your Employer complete the employer section and then give it to your attending physician. Your physician should fill out his or her section of the form and send it directly to UNUM. Alternatively, you may follow any claims filing procedures approved by your Employer and UNUM. Your Employer will separately advise you of any such procedures.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Your proof of claim, provided at your expense, must show:

- that you are under the regular care of a physician;
- the appropriate documentation of your earnings;
- the date your disability began;
- the cause of your disability;
- the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
- the name and address of any hospital, institution or other source where you received treatment, including all attending physicians’ names and addresses.

The Plan may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of a request by the Plan.

In some cases, you will be required to give UNUM and the Plan authorization to obtain additional medical information, and to provide non-medical information as part of your proof of claim, or
proof of continuing disability. The Plan will deny your claim, or stop sending you payments, if the appropriate information is not submitted.

TO WHOM WILL PAYMENTS BE MADE?

Payments will be made to you.

WHAT HAPPENS IF YOUR CLAIM IS OVERPAID?

The Plan Sponsor has the right to recover any overpayments due to:

- fraud;
- any error made in processing a claim; and
- your receipt of Deductible Sources of Income.

You must repay the Plan Sponsor for any overpayment in your claim. Alternatively, your Employer may reduce or eliminate future payments instead of requiring repayment.

FRAUD WARNING

The Plan Sponsor and your Employer take fraud very seriously. If you, with intent to defraud or knowing that you are facilitating a fraud against the Plan, submit an application or file a claim containing a false or deceptive statement, the Plan Sponsor and/or your Employer will assert all legal and equitable rights against you and pursue all legal and equitable remedies the Plan Sponsor and/or your Employer has against you.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

Unless special circumstances apply, all administrative appeal procedures offered by the Plan must be completed before you begin any legal action regarding your claim. In no event, can you start any legal action regarding your claim more than three years from the time proof of claim is required, unless other timeframes apply under federal law.

CLAIM AND APPEAL PROCEDURES

Upon receipt of the required proof of claim, a decision on your claim will be made promptly. If you fail to supply the needed information, your claim will be denied.

Please see Article VI of this SPD for the Plan’s claim and appeal procedures.

VIII. Definitions

ACTIVE EMPLOYMENT means you are working for your Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under Eligible Group(s).

Your work site must be:

- your Employer’s usual place of business;
- an alternative work site at the direction of your Employer, including your home; or
· a location to which your job requires travel

You will also be considered “actively employed” (i) while you are on an approved paid sabbatical or administrative leave from your Employer, (ii) during academic breaks, breaks between semesters or “closure” periods during which no meals are served or interim periods between seasonal jobs, or (iii) while you otherwise remain eligible for benefits in the records of Human Resources.

**BI-WEEKLY BENEFIT** means the total benefit amount an Eligible Employee is eligible for under the Plan subject to the maximum benefit.

**BI-WEEKLY EARNINGS** generally means your gross stated salary from your Employer just prior to your disability as defined in this booklet. If your gross stated salary is increased by the Employer during your period of disability, your Bi-Weekly Earnings will be adjusted to reflect the salary increase.

**BI-WEEKLY PAYMENT** means your payment after any Deductible Sources of Income have been subtracted from your gross disability payment.

**CALIFORNIA STATE DISABILITY** means the State Disability Insurance Program under California law, providing temporary benefit payments to California workers for non-work-related disabilities.

**CALIFORNIA WAGE CEILING** means 100% of the California State Quarterly Earnings Maximum times four.

**CALIFORNIA WEEKLY MAXIMUM** means the maximum weekly benefit payable under the California State Disability.

**DEDUCTIBLE SOURCES OF INCOME** means income from deductible sources listed in the Plan which you receive or are entitled to receive while you are disabled. This income will be subtracted from your gross disability payment.

**DISABILITY EARNINGS** means the earnings which you receive while you are disabled and working, plus the earnings you could reasonably be expected to receive if you were working to your maximum capacity.

**ELIMINATION PERIOD** means a period of continuous disability which must be satisfied before you are eligible to receive benefits from UNUM.

**EMPLOYEE** means a person who is in active employment on the United States payroll with his or her Employer. Temporary, seasonal, and on-call workers are excluded from the coverage.

**GROSS DISABILITY PAYMENT** means the benefit amount before the Plan subtracts Deductible Sources of Income and Disability Earnings.
**HOSPITAL OR INSTITUTION** means a facility licensed to provide medical care and treatment for the condition causing your disability.

**INJURY** means a bodily injury that is the result of an accident.

**LAW, PLAN OR ACT** means the original enactments of any law, Plan or act and all amendments.

**LAYOFF** or **LEAVE OF ABSENCE** means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by your Employer. Your normal vacation time or any period of disability is not considered a temporary layoff or leave of absence.

**LIMITED** means what you cannot or are unable to do.

**MATERIAL AND SUBSTANTIAL DUTIES** means those duties that:

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified, except that if you are required to work on average in excess of 40 hours per week, the Plan will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

**MAXIMUM CAPACITY** means, based on your restrictions and limitations, the greatest extent of work you are able to do in your regular occupation that is reasonably available.

**MAXIMUM PERIOD OF PAYMENT** means the longest period of time the Plan will make payments to you for any one period of disability.

**OCCUPATIONAL SICKNESS OR INJURY** means a Sickness or Injury that was caused by or aggravated by any employment for pay or profit.

**PART-TIME BASIS** means the ability to work and earn between 20% and 80% of your Bi-Weekly Earnings.

**PAYABLE CLAIM** means a claim for which the Plan is liable.

**PHYSICIAN** means:

- a person performing tasks that are within the limits of his or her medical license; and
- a person who is licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
- a person with a doctoral degree in Psychology (Ph.D. or Psy.D.) whose primary practice is treating patients; or
- a person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction.

You, or your spouse, children, parents or siblings will not be considered as a physician for a claim that you send to the Plan.
**REGULAR CARE** means:

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving the most appropriate treatment and care, which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s).

**REGULAR OCCUPATION** means the occupation you are routinely performing when your disability begins.

**SALARY CONTINUATION OR ACCUMULATED SICK LEAVE** means continued payments to you by the Employer of all or part of your Bi-Weekly earnings, after you become disabled as defined by the Plan. Salary continuation or accumulated sick leave does not include compensation paid to you by your Employer for work you actually perform after your disability begins. Such compensation is considered disability earnings and would be taken into account in calculating your Bi-Weekly payment.

**SICKNESS** means an illness or disease. Disability must begin while you are covered under the Plan.

**UNUM** means the organization engaged to provide certain administrative claims handling services for the short-term disability insurance benefits under this Plan.

**WAITING PERIOD** means the continuous period of time (shown in the Summary of Benefits) that you must be in active employment as an Eligible Employee before you are eligible for short-term disability insurance benefits under the Plan.

**YOU** means a person who is eligible for short-term disability insurance benefits under the Plan.
APPENDIX K

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM

INTRODUCTION

The Middlebury Employee and Family Assistance Program ("EFAP") is designed to assist individuals in accessing professional help for personal issues that may be concerning the individual or affecting his/her work.

ELIGIBILITY REQUIREMENTS

The EFAP is available free of charge for ALL active Employees, their Dependents, and others residing in the Employee’s home. In addition, student employees of MIIS are eligible for the EFAP. (Employees whose primary relationship with the Employer is that of Middlebury students are not eligible for this benefit.)

EMPLOYEE AND FAMILY ASSISTANCE PROGRAM

EFAP provides counseling and referral services for a range of quality of life issues: alcohol and/or drug abuse, marital difficulties, child/parent relationship concerns, or other personal or family situations.

Middlebury has a contract with E-4 (LifeScope) to provide the these benefits, and such benefits are only available through E-4 (LifeScope).

BENEFITS

- Six free face-to-face counseling sessions per person, per issue, each year, except where prohibited by state law, are available to Eligible Employee households.


- Child and Elder Care Referrals: Qualified searches and referrals for prenatal, adoption, child care, parenting, summer care, mature transitions, share care, special needs, at-risk/high-risk adolescents, academic services (primary and secondary), academic services (colleges and universities), emergency/temporary care (child and adult options), grandparents as parents, adult care, disaster relief, and personal services.

- Legal Consultations: Free phone consultations and additional discounted services.

- Financial Consults: Information about financial planning and investments.
• Budget & Debt Counseling: Phone consultation on budgeting and debt problems.

CONTACT INFORMATION
To access the Middlebury Employee and Family Assistance Program benefits, please contact E-4 24/7 at 800-828-6025 or log on to their website at:

   www.lifescopeeap.com
   User name: Middlebury College
   Password: guest   (User name and Password not case sensitive)
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
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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 a 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.
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.
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.


10.10. **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.
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.

<table>
<thead>
<tr>
<th>Vision Care Services</th>
<th>Member Doctor Benefit</th>
<th>Non-Member Provider Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Examination</td>
<td>Covered in Full*</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.

<table>
<thead>
<tr>
<th>Vision Care Materials</th>
<th>Member Doctor Benefit</th>
<th>Non-Member Provider Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lenses</td>
<td>Covered in Full*</td>
<td>Up to $ 30.00*</td>
</tr>
<tr>
<td>Single Vision</td>
<td>Covered in Full*</td>
<td>Up to $ 50.00*</td>
</tr>
<tr>
<td>Bifocal</td>
<td>Covered in Full*</td>
<td>Up to $ 65.00*</td>
</tr>
<tr>
<td>Trifocal</td>
<td>Covered in Full*</td>
<td>Up to $ 100.00*</td>
</tr>
<tr>
<td>Lenticular</td>
<td>Covered in Full*</td>
<td></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>
</tbody>
</table>

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.

Supplementary Care

75% of Cost | 75% of Cost* |

Subsequent low vision therapy.

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.
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.
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 children of the domestic partner provided they depend upon the Enrollee for support and maintenance.
Global Health Advantage
2-20 Lives Platinum Plan

GROUP INSURANCE PLAN

CN004
716660 – 1/1/2017
Printed in U.S.A.

These materials are being made available electronically for your convenience. Cigna has provided the final documents to your employer. Care should be taken to ensure you are reviewing the most complete, accurate and up to date version. Any questions regarding content may be directed to your employer or Cigna.
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CIGNA HEALTH AND LIFE INSURANCE COMPANY
a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

GROUP POLICY(S) — COVERAGE

PREFERRED PROVIDER MEDICAL BENEFITS
EMERGENCY EVACUATION OR REPATRIATION BENEFIT (IF APPLICABLE)
CIGNA VISION
CIGNA DENTAL PREFERRED PROVIDER BENEFITS (IF APPLICABLE)
PRESCRIPTION DRUG BENEFITS

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.

Anna Krishul, Corporate Secretary
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. You can access a list of Participating Providers in your area at www.cignaenvoy.com. 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 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. 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.

How To File Your Claim

There’s no paperwork for U.S. 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. U.S. Out-of-Network and International 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 form at www.cignaenvoy.com
or from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing Cigna Service Center.

You must follow the Predetermination of Benefits procedure when it is necessary for dental forms.

CLAIM REMINDERS
- BE SURE TO USE YOUR EMPLOYEE ID AND ACCOUNT NUMBER WHEN YOU FILE CIGNA’S CLAIM FORMS, OR WHEN YOU CALL THE CIGNA SERVICE CENTER.
- YOUR EMPLOYEE ID AND ACCOUNT NUMBER ARE SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of U.S. Out-of-Network & International Claims
Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) for U.S. Out-of-Network and International 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 one year for U.S. Out-of-Network and International 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 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
None

Classes of Eligible Employees
The following Classes of Employees are eligible for this insurance:
- All full time Expatriate, Third Country National and select Key Local National Employees working outside the United States as reported by the Policyholder.

“Expatriate” means an Employee who is working outside his country of citizenship (for U.S. citizens, an employee working outside their home country or outside the United States for at least 180 days in a consecutive 12 month period that overlaps with the plan year and their covered dependents).

“Third Country National” generally means an Employee who works outside his country of citizenship and outside the Employer’s country of domicile.

“Key Local National” means an employee of the Policyholder working and residing within his country of citizenship and who the Policyholder has designated as essential to the management of that country’s operation.

Persons for whom coverage is prohibited under applicable law will not be considered eligible under this plan.

Employee Insurance
This plan is offered to you as an Employee. To be insured, you may be required to pay part of the cost.

Effective Date of Your Insurance
If you do not contribute towards the cost of the premium, you will become insured on the date you become eligible.

If you do contribute towards the cost of the premium, you will become insured on the date you elect the insurance by signing an Enrollment and Change Form, but no earlier than the date you become eligible. If you are a Late Entrant, your insurance will not become effective until Cigna agrees to insure you.

You will not be denied enrollment for Medical Insurance due to your health status.

You will become insured on the date you become eligible, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.
Late Entrant - Employee
You are a Late Entrant if you are required to contribute towards the cost of the premium and:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you have previously canceled the coverage.

Dependent Insurance
For your Dependents to be insured, you may be required to pay part of the cost of Dependent Insurance.

Effective Date of Dependent Insurance
If you do not contribute towards the cost of the premium for your Dependents, insurance for your Dependents will become effective on the date you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you do contribute towards the cost of the premium for your Dependents, insurance for your Dependents will become effective on the date you elect it by signing an Enrollment and Change Form, but no earlier than the date you become eligible for Dependent Insurance.

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until Cigna agrees to insure that Dependent. Your Dependent will not be denied enrollment for Medical Insurance due to health status.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent
You are a Late Entrant for Dependent Insurance if you are required to contribute towards the cost of the premium for Dependent Insurance and:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you canceled the coverage.

A Dependent spouse or minor child enrolled within 30 days following a court order of such coverage will not be considered a Late Entrant.

Exception for Newborns
Any Dependent child born while you are insured for Medical Insurance will become insured for Medical Insurance on the date of his birth if you elect Dependent Medical Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.
## Preferred Provider Medical Benefits

### The Schedule

#### For You and Your Dependents
Preferred Provider Medical Benefits provide coverage for care in the United States (In & Out-of-Network) and International. 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 Copayment or Coinsurance.

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

#### Copayments
Copayments are expenses to be paid by you or your Dependent for covered services. Copayments are in addition to any Coinsurance.

#### Out-of-Pocket Expenses
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.
- Copayments.

Once the Out-of-Pocket Maximum is reached for covered services that apply to the Out-of-Pocket Maximum, any copayments are no longer required.

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 Out-of-Pocket Maximums
Out-of-Pocket Maximums will cross-accumulate between U.S. In-Network, U.S. Out-of-Network and International. All other plan maximums and service-specific maximums (dollar and occurrence) will also cross-accumulate.

#### 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.

#### Assistant Surgeon and Co-Surgeon Charges

##### Assistant Surgeon
The maximum amount payable will be limited to charges made by an assistant surgeon as specified in Cigna Reimbursement Policies.

##### Co-Surgeon
The maximum amount payable will be limited to charges made by co-surgeons as specified in Cigna Reimbursement Policies.
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>INTERNATIONAL</th>
<th>U.S. IN-NETWORK</th>
<th>U.S. OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Emergency Evacuation or Repatriation Benefits</td>
<td>100% *</td>
<td>100%*</td>
<td>100% *</td>
</tr>
<tr>
<td>*Only applicable if elected by your Employer.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Percentage of Covered Expenses the Plan Pays</td>
<td>100%</td>
<td>100%</td>
<td>100% of the Maximum Reimbursable Charge</td>
</tr>
<tr>
<td>Maximum Reimbursable Charge</td>
<td></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 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: • 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 the Insurance Company.</td>
<td>U.S. Claims Only</td>
<td>Not Applicable</td>
<td>150%</td>
</tr>
</tbody>
</table>

*The Percentage of Covered Expenses the Plan Pays* | ```

<table>
<thead>
<tr>
<th>Benefit Highlight</th>
<th>International</th>
<th>U.S. In-Network</th>
<th>U.S. Out-Of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Emergency Evacuation or Repatriation Benefits</td>
<td>100% *</td>
<td>100%*</td>
<td>100% *</td>
</tr>
<tr>
<td><em>Only applicable if elected by your Employer.</em></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>The Percentage of Covered Expenses the Plan Pays</td>
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<td>100%</td>
<td>100% of the Maximum Reimbursable Charge</td>
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<tr>
<td>Maximum Reimbursable Charge</td>
<td></td>
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</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 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: • 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 the Insurance Company.</td>
<td>U.S. Claims Only</td>
<td>Not Applicable</td>
<td>150%</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>INTERNATIONAL</td>
<td>U.S. IN-NETWORK</td>
<td>U.S. OUT-OF-NETWORK</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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</tr>
<tr>
<td>Maximum Reimbursable Charge (Cont.)</td>
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<td></td>
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<tr>
<td><strong>Note:</strong></td>
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<tr>
<td>The provider may bill you for the difference</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>between the provider’s normal charge and the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Reimbursable Charge, in addition to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>applicable coinsurance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,000 per person</td>
<td>$1,000 per person</td>
<td>$1,000 per person</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$3,000 per family</td>
<td>$3,000 per family</td>
<td>$3,000 per family</td>
</tr>
<tr>
<td>Family members meet only their individual</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Out-of-Pocket and then their claims will be</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>covered at 100%; if the family Out-of-Pocket</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>has been met prior to their individual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket being met, their claims will</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>be paid at 100%.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Combined Medical/Pharmacy Out-of-Pocket</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined Medical/Pharmacy Out-of-Pocket:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>includes retail and home delivery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>prescription drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Physician’s Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office visit</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Surgery Performed In the Physician’s Office</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Second Opinion Consultations (provided on a\n\n</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>voluntary basis)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Treatment</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>INTERNATIONAL</td>
<td>U.S. IN-NETWORK</td>
<td>U.S. OUT-OF-NETWORK</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>---------------</td>
<td>-----------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Preventive Care</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>- all ages</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Immunizations - all ages</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Travel Immunizations</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>For Employees and Dependents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drug Benefit</strong></td>
<td>100%</td>
<td>Refer to the Prescription Drug Benefits Schedule</td>
<td>Refer to the Prescription Drug Benefits Schedule</td>
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<tr>
<td>Purchased outside the United States</td>
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<td></td>
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<tr>
<td><strong>Mammograms, PSA, PAP Smear and Colorectal Cancer Screenings</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td><strong>Lead Poisoning Screening Tests</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>For Children under age 6</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Inpatient Hospital - Facility Services</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Semi-Private Room and Board</td>
<td>Limited to the semi-private room rate</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 rate (Private Room covered outside the United States only if no semi-private room equivalent is available)</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 ICU/CCU daily room rate</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>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Physician’s Visits/Consultations</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>U.S. OUT-OF-NETWORK</td>
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</tr>
<tr>
<td><strong>Inpatient Hospital Professional Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Radiologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Professional Services</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiologist</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pathologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anesthesiologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Professional services (radiology, pathology and ER Physician)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>X-ray and/or Lab performed at the Emergency Room (billed by the facility as part of the ER visit)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Independent x-ray and/or Lab Facility in conjunction with an ER visit</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>BENEFIT HIGHLIGHTS</td>
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<td>U.S. OUT-OF-NETWORK</td>
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</tr>
<tr>
<td>Urgent Care Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Ambulance</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Inpatient Services at Other Health Care Facilities</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 120 days combined</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Laboratory and Radiology Services (includes pre-admission testing)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Hospital Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Independent X-ray and/or Lab Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>INTERNATIONAL</td>
<td>U.S. IN-NETWORK</td>
<td>U.S. OUT-OF-NETWORK</td>
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<tr>
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</tr>
<tr>
<td>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Independent X-ray Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Short-Term Rehabilitative Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Speech Therapy</td>
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<td></td>
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<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary Rehab</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Short-Term Rehabilitative Therapy maximum does not apply to the treatment of autism and/or Mental Health and Substance Use Disorder conditions.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Chiropractic Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Calendar Year Maximum:</td>
<td>20 days</td>
<td>Unlimited</td>
<td>20 days</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>INTERNATIONAL</td>
<td>U.S. IN-NETWORK</td>
<td>U.S. OUT-OF-NETWORK</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
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<td>---------------------</td>
</tr>
<tr>
<td>Alternative Therapies and Non-traditional Medical Services (Outside the United States)</td>
<td>100%</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Herbalist, Massage Therapist, Naturopath</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum: $1,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Calendar Year Maximum: 120 days (includes outpatient private nursing when approved as medically necessary) (The limit is not applicable to Mental Health and Substance Use Disorder conditions.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>(same coinsurance level as Home Health Care)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bereavement Counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services provided as part of Hospice Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>100%</td>
<td>100%</td>
<td>100%</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>
<td>Covered under Mental Health Benefit</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
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<td>U.S. IN-NETWORK</td>
<td>U.S. OUT-OF-NETWORK</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------</td>
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<td>---------------------</td>
</tr>
<tr>
<td>Maternity Care Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Visit to Confirm Pregnancy</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>All subsequent Prenatal Visits, Postnatal Visits and Physician’s Delivery Charges (i.e. global maternity fee)</td>
<td>100%</td>
<td>100%</td>
<td>100%</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>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Delivery – Facility (Inpatient Hospital, Birthing Center)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Abortion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes elective and non-elective procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
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<td>U.S. OUT-OF-NETWORK</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>---------------</td>
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<td>---------------------</td>
</tr>
<tr>
<td>Women’s Family Planning Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits and Counseling</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Lab and Radiology Tests</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Note:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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. Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
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<td>U.S. OUT-OF-NETWORK</td>
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<tr>
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</tr>
<tr>
<td><strong>Men’s Family Planning Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits and Counseling</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Lab and Radiology Tests</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Surgical Sterilization Procedures for Vasectomy (excludes reversals)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Outpatient Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Physician’s Services</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
### Infertility Treatment

Services Not Covered include:

- Testing performed specifically to determine the cause of infertility.
- Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).
- Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).

**Note:**
Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>INTERNATIONAL</th>
<th>U.S. IN-NETWORK</th>
<th>U.S. OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility Treatment</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Services Not Covered include:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Testing performed specifically to determine the cause of infertility.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>- Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).</td>
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</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>INTERNATIONAL</td>
<td>U.S. IN-NETWORK</td>
<td>U.S. OUT-OF-NETWORK</td>
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</tr>
<tr>
<td><strong>Organ Transplants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes all medically appropriate, non-experimental transplants</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Lifetime Travel Maximum: $10,000 per transplant</td>
<td>Not Covered</td>
<td>No Charge (only available when using Lifesource facility)</td>
<td>Not Covered U.S. In-Network Coverage Only</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>External Prosthetic Appliances</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Diabetic Equipment</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>TMJ Treatment</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Benefit Lifetime Maximum: $1,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Benefit</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>One examination per 24 month period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Aid Maximum</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Up to $1,000 per hearing aid unit necessary for each hearing impaired ear every 3 years for a dependent child under age 24.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Wigs (for hair loss due to alopecia areata)</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Calendar Year Maximum: $500</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th>Nutritional Evaluation</th>
<th>INTERNATIONAL</th>
<th>U.S. IN-NETWORK</th>
<th>U.S. OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 visits per person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>however, the 3 visit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>limit will not apply</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to treatment of diabetes and/or to Mental Health and Substance Use Disorder conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Nutritional Formulas</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Dental Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Office Visit</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</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.
<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>INTERNATIONAL</th>
<th>U.S. IN-NETWORK</th>
<th>U.S. OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Facility</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Includes Acute Inpatient and Residential Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlimited Maximum per Calendar Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient – Office Visits</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Includes Individual, Family and Group Psychotherapy; Medication Management, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlimited Maximum per Calendar Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient – All Other Services</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Includes Partial Hospitalization, Intensive Outpatient Services, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlimited Maximum per Calendar Year</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>BENEFIT HIGHLIGHTS</td>
<td>INTERNATIONAL</td>
<td>U.S. IN-NETWORK</td>
<td>U.S. OUT-OF-NETWORK</td>
</tr>
<tr>
<td>----------------------------------------</td>
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<td>---------------------</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Facility</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% Maximum per Calendar Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient – Office Visits</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Includes Individual, Family and Group Psychotherapy; Medication Management, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% Maximum per Calendar Year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient – All Other Services</strong></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Includes Partial Hospitalization, Intensive Outpatient Services, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% Maximum per Calendar Year</td>
<td></td>
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</tbody>
</table>
Preferred Provider Medical Benefits

Certification Requirements – U.S. 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 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:

- 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 – U.S. 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;
- nonemergency ambulance; 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 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 anesthetics 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 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 or in connection with mammograms including: a baseline mammogram for asymptomatic women at least age 35; a mammogram every one or two years for asymptomatic women ages 40-49, but no sooner than two years after a woman's baseline mammogram; an annual mammogram for women age 50 and over; and when prescribed by a Physician, a mammogram, anytime, regardless of the woman's age.
- charges made for or in connection with travel immunization for Employees and Dependents.
- surgical or nonsurgical treatment of TMJ dysfunction.
- charges made for or in connection with one baseline lead poison screening test for Dependent children at or around 12 months of age, or in connection with lead poison screening and diagnostic evaluations for Dependent children under the age of 6 years who are at high risk for lead poisoning according to guidelines set by the Division of Public Health.
- charges made for children from birth through age 18 for immunization against: diphtheria; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; Haemophilus influenzae B; and hepatitis A.
- charges made for U.S. FDA approved prescription contraceptive drugs and devices and for outpatient contraceptive services including consultations, exams, procedures, and medical services related to the use of contraceptives and devices.
- charges made for Diabetic supplies as recommended in writing or prescribed by a Participating Physician or Other Participating Health Care Professional, including insulin pumps and blood glucose meters.
- scalp hair prosthesis worn due to alopecia areata.
- colorectal cancer screening for persons 50 years of age or older or those at high risk of colon cancer because of family history of familial adenomatous polyposis; family history of
hereditary nonpolyposis colon cancer; chronic inflammatory bowel disease; family history of breast, ovarian, endometrial, colon cancer or polyps; or a background, ethnicity or lifestyle such that the health care provider treating the participant or beneficiary believes he or she is at elevated risk. Coverage will include screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging or other screening modalities, provided as determined by the Secretary of Health and Social Services of Delaware after consideration of recommendations of the Delaware Cancer Consortium and the most recently published recommendations established by the American College of Gastroenterology, the American Cancer Society, the United States Preventive Task Force Services, for the ages, family histories and frequencies referenced in such recommendations and deemed appropriate by the attending Physician. Also included is the use of anesthetic agents, including general anesthesia, in connection with colonoscopies and endoscopies performed in accordance with generally-accepted standards of medical practice and all applicable patient safety laws and regulations, if the use of such anesthetic agents is medically necessary in the judgment of the treating Physician.

- charges for hearing loss screening tests of newborns and infants provided by a Hospital before discharge.

**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;
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications; and
- routine patient care costs (as defined) for covered persons engaging in clinical trials for treatment of life threatening diseases.
Routine patient care costs do not include:

- the investigational drug, item, device, or service, itself; or
- 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.

**Telehealth Services**

Charges for the delivery of telehealth services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state, while such patient is at an originating site and the health care provider is at a distant site.

**Orthognathic Surgery**

- orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not 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.

**Home Health Services**

- charges made for Home Health Services when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility.

Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered.
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;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;

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 not 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.

**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 abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, a group, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program. Substance Use Disorder Partial Hospitalization services are rendered not 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
    posturalpedic 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.

External Prosthetic Appliances and Devices
• charges made or ordered by a Physician for: the initial
  purchase and fitting of external prosthetic appliances and
  devices available only by prescription which are necessary for
  the alleviation or correction of Injury, Sickness or congenital
  defect. Coverage for External Prosthetic Appliances is limited
  to the most appropriate and cost effective alternative as
  determined by the utilization review Physician.

External prosthetic appliances and devices shall include
prostheses/prosthetic appliances and devices, orthoses and
orthotic devices; braces; and splints.

Prostheses/prosthetic Appliances and Devices
Prostheses/prosthetic appliances and devices are defined as
fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

• basic limb prostheses;
• terminal devices such as hands or hooks; and
• speech prostheses.

Orthoses and Orthotic Devices
Orthoses and orthotic devices are defined as orthopedic
appliances or apparatuses used to support, align, prevent or
correct deformities. Coverage is provided for custom foot
orthoses and other orthoses as follows:

• Nonfoot orthoses – only the following nonfoot orthoses are
  covered:
  • rigid and semirigid custom fabricated orthoses;
  • semirigid prefabricated and flexible orthoses; and
  • rigid prefabricated orthoses including preparation, fitting
    and basic additions, such as bars and joints.

• 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 plagiocephaly. 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.

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Short-Term Rehabilitative Therapy
Short-term Rehabilitative Therapy is that part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

• occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Short-term Rehabilitative Therapy 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; and
• maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.

Multiple outpatient services provided on the same day constitute one day.

Services that are provided by a chiropractic Physician are not covered. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain, and improve function.

Chiropractic Care Services
Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function.

The following limitation applies to 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.
Chiropractic Care services that are not covered include but are not limited to:

- 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;
- maintenance or treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient’s current status;
- vitamin therapy.

Alternative Therapies and Non-traditional Medical Services

Charges for Alternative Therapies and Non-traditional medical services limited to $1,000 per calendar year. Alternative Therapies and Non-traditional medicine include services provided by an Herbalist, or Naturopath, or for Massage Therapy when these services are provided for a covered condition outside the United States in accordance with customary local practice and the practitioner is operating within the scope of his/her license, and the treatment is medically necessary, cost-effective, and provided in an appropriate setting.

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 bras 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. 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.

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 U.S. 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, 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 (U.S. In-Network Coverage Only)

Charges made for reasonable 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, lodging and food 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); lodging while at, or traveling to and from the transplant site; and food 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. The following are specifically excluded travel expenses: travel costs incurred due to travel within 60 miles of your home; 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 transplant. No benefits are available when the covered person is a donor.

Prescription Drug Benefits (purchased outside the United States)

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 Drugs or Related Supplies ordered by a Physician outside the United States, Cigna will provide coverage for those expenses as shown in the Medical Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Coinsurance shown in the Schedule, after you have satisfied your Prescription Drug Deductible, if applicable. Please refer to the Schedule for any required Coinsurance or Maximums if applicable.

Exclusions:

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by applicable law;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectable used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription vitamins (other than prenatal vitamins) and dietary supplements;
- biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications;
- anabolic steroids;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the origi
## Prescription Drug Benefits

### The Schedule

**This section describes coverage for Prescriptions obtained inside the United States only.** Prescriptions obtained outside of the United States are covered under the Preferred Provider Medical Benefits section of this certificate.

**For You and Your Dependents**

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies 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 Drugs and Related Supplies. That portion includes any applicable Copayment and/or Coinsurance.

**Coinsurance**

The term Coinsurance means the percentage of Charges for covered Prescription Drugs and Related Supplies that you or your Dependent are required to pay under this plan.

**Charges**

The term Charges means the amount charged by the Insurance Company to the plan when the Pharmacy is a Participating Pharmacy, and it means the actual billed charges when the Pharmacy is a non-Participating Pharmacy.

**Copayments**

Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies.

### BENEFIT HIGHLIGHTS

<table>
<thead>
<tr>
<th></th>
<th>PARTICIPATING PHARMACY</th>
<th>Non-PARTICIPATING PHARMACY</th>
</tr>
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<tbody>
<tr>
<td><strong>Retail Prescription Drugs</strong></td>
<td>The amount you pay for each 30-day supply</td>
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</tr>
<tr>
<td>Medications required as part of preventive care services (detailed information is available at <a href="http://www.healthcare.gov/">www.healthcare.gov/</a>) are covered at 100% with no copayment.</td>
<td></td>
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<tr>
<td>Generic*</td>
<td>$0 copay</td>
<td>$25 copay</td>
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<tr>
<td>Brand-Name*</td>
<td>$25 copay</td>
<td>$25 copay</td>
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<tr>
<td><strong>Home Delivery Prescription Drugs</strong></td>
<td>The amount you pay for each 90-day supply</td>
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</tr>
<tr>
<td>Medications required as part of preventive care services (detailed information is available at <a href="http://www.healthcare.gov/">www.healthcare.gov/</a>) are covered at 100% with no copayment.</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>U.S. In-Network coverage only</td>
</tr>
<tr>
<td>Brand-Name*</td>
<td>$75 copay</td>
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</table>
Prescription Drug Benefits
For You and Your Dependents

Covered Expenses
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 Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription 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 is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

Limitations
Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply at a retail Pharmacy unless limited by the drug manufacturer's packaging; or
- up to a consecutive 90-day supply at a home delivery Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

In the event that you insist on a more expensive “brand-name” drug where a “generic” drug would otherwise have been dispensed, you will be financially responsible for the amount by which the cost of the “brand-name” drug exceeds the cost of the “generic” drug, plus the required Copayment identified in the Schedule.

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to Cigna to request a prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P&T Committee clinically evaluates the Prescription Drug for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Your Payments
Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance shown in the Schedule. Please refer to the Schedule for any required Copayments, Coinsurance or Maximums if applicable.

When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for your, or your Dependent’s convenience, a Copayment will apply to each Prescription Drug.

Exclusions
No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law;
• any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
• a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
• injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
• Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
• prescription vitamins (other than prenatal vitamins), dietary supplements unless state or federal law requires coverage of such drugs;
• prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
• implantable contraceptive products;
• diet pills or appetite suppressants (anorectics);
• anabolic steroids;
• prescription smoking cessation products, unless state or federal law requires coverage of such products;
• biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications;
• drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
• replacement of Prescription Drugs and Related Supplies due to loss or theft;
• drugs used to enhance athletic performance;
• drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
• prescriptions more than one year from the original date of issue;
• any drugs that are experimental or investigational as described under the Medical “Exclusions” section of your certificate.

Other limitations are shown in the Medical “Exclusions” section of your certificate.

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Copayment or Coinsurance shown in the Schedule at the time of purchase. You do not need to file a claim form.

If you or your Dependents purchase your Prescription Drugs or Related Supplies through a non-Participating Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a home delivery Participating Pharmacy, see your home delivery drug introductory kit for details, or contact member services for assistance.

See your Employer's Benefit Plan Administrator to obtain the appropriate claim form.
Emergency Evacuation (If Applicable)
If you suffer a life-threatening/limb-threatening medical condition, and Cigna, and/or its designee, determines that adequate medical facilities are not available locally, Cigna, or its designee, will arrange for an emergency evacuation to the nearest facility capable of providing adequate care. You must contact Cigna at the phone number indicated on your identification card to begin this process.

In making their determinations, Cigna, and/or its designee, will consider the nature of the emergency, your condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered. Your medical condition must require the accompaniment of a qualified healthcare professional during the entire course of your evacuation to be considered an emergency and requiring emergency evacuation. Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

Repatriation
Following any covered emergency evacuation, Cigna will pay for one of the following:

1. If it is deemed Medically Necessary and appropriate by the Cigna medical director, you will be transferred to your permanent residence via a one-way economy airfare or;
2. You will be transferred back to your original work location or the location from which you were evacuated via a one-way economy airfare.

If your transportation needs to be medically supervised a qualified medical attendant will escort you. Additionally, if Cigna and/or its designee, determines a mode of transport other than economy class seating on a commercial aircraft is required, Cigna or its designee will arrange accordingly and such will be covered by Cigna.

Notification
Expenses incurred for your evacuation or repatriation without the approval and authorization of Cigna and/or its designee will not be Covered Expenses. Only those expenses approved by Cigna will be eligible for coverage and/or reimbursement under the terms of your plan.

Emergency Family Travel Arrangements and Confinement Visitation
If Cigna determines that you are expected to require hospitalization in excess of 7 days at the location to which you are to be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by you. If your Dependent Child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent child is hospitalized.

Return of Dependent Children
If Dependent child(ren) are left unattended by virtue of the evacuee’s absence alone following a covered evacuation, a one-way economy airfare will be provided to their place of residence.

Repatriation of Mortal Remains
The costs associated with the transportation of mortal remains from the place of death to the home country will be covered. In addition, assistance will be provided by Cigna or its designee for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

General Limitations/Exclusions for Evacuation Benefits
No payment will be made for charges for:
• services rendered without the authorization or intervention of Cigna or its designee;
• non-emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious injury or harm to you;
• a condition which would allow for treatment at a future date convenient to you and which does not require emergency evacuation or repatriation;
• medical care or services scheduled for member or provider’s convenience which are not considered an emergency;
• expenses incurred if the original or ancillary purpose of your trip is to obtain medical treatment;
• services provided for which no charge is normally made;
• expenses incurred while serving in the armed forces of another country;
• transportation for your vehicle and/or other personal belongings involving intercontinental and/or marine transportation;
• service provided other than those indicated in this certificate;
• injury or sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action;
• death caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action; or
• for claim payments that are illegal under applicable law.
## Cigna Vision
### The Schedule
For You and Your Dependents

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th>INTERNATIONAL</th>
<th>U.S. IN-NETWORK</th>
<th>U.S. OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examinations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One Eye Exam every 24 Consecutive months</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Lenses &amp; Frames</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One pair of glasses or contact lenses per 24 Consecutive months</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Maximum Benefit: $250</td>
<td></td>
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</tr>
</tbody>
</table>
Vision Benefits
For You and Your Dependents

Covered Expenses
Benefits Include:

Examinations – one vision and eye health evaluation including but not limited to eye health examination, dilation, refraction and prescription for glasses.

Lenses (Glasses) – One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms).
- Polycarbonate lenses for children under 18 years of age;
- Oversize lenses;
- Rose #1 and #2 solid tints;
- Progressive lenses covered up to bifocal lenses amount.

Frames – One frame – choice of frame covered up to retail plan allowance.

Contact Lenses – One pair or a single purchase of a supply of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year). Contact lens allowance can be applied towards contact lens materials as well as the cost of supplemental contact lens professional services including fitting and evaluation, up to the stated allowance.

Expenses Not Covered
Covered Expenses will not include, and no payment will be made for:
- Orthoptic or vision training and any associated supplemental testing.
- Spectacle lens treatments, “add ons”, or lens coatings not shown as covered in the Schedule.
- Two pair of glasses, in lieu of bifocals or trifocals.
- Prescription sunglasses.
- Medical or surgical treatment of the eyes.
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
- Magnification or low vision aids.
- Any non-prescription eyeglasses, lenses, or contact lenses.
- Safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- Charges in excess of the usual and customary charge for the service or materials.
- Charges incurred after the Policy ends or the Insured's coverage under the Policy ends, except as stated in the Policy.
- Experimental or non-conventional treatment or device.
- High Index lenses of any material type.
- Lens treatments or “add-ons”, except rose tints (#1 & #2), and oversize lenses.
- For or in connection with experimental procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related.
- Claims submitted and received in-excess of one year (365 days) from the original Date of Service.

Other Limitations are shown in the Exclusions and General Limitations section.
Cigna Dental Preferred Provider Insurance – Option 1 (If Applicable)

The Schedule

**For You and Your Dependents**
The Dental Benefits Plan offered by your Employer includes Participating and non-Participating Providers.

**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 agreed upon by the provider and the Insurance Company.

**Non-Participating Provider Payment**
U.S. Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area.

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Classes I, II, III Combined Calendar Year Maximum</strong></td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$50 per person</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>$150 per family</td>
</tr>
<tr>
<td><strong>Class I</strong></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100% not subject to plan deductible</td>
</tr>
<tr>
<td><strong>Class II</strong></td>
<td></td>
</tr>
<tr>
<td>Basic Restorative</td>
<td>80% after plan deductible</td>
</tr>
<tr>
<td><strong>Class III</strong></td>
<td></td>
</tr>
<tr>
<td>Major Restorative</td>
<td>50% after plan deductible</td>
</tr>
</tbody>
</table>
# Cigna Dental Preferred Provider Insurance – Option 2 (If Applicable)

## The Schedule

### For You and Your Dependents
The Dental Benefits Plan offered by your Employer includes Participating and non-Participating Providers.

### 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 agreed upon by the provider and the Insurance Company.

### Non-Participating Provider Payment
U.S. Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area.

## BENEFIT HIGHLIGHTS

| Classes I, II, III Combined Calendar Year Maximum | $1,500 |
| Class IV Lifetime Maximum | $1,500 |
| **Calendar Year Deductible** |  |
| Individual | $50 per person |
| Family Maximum | $150 per family |
| **Class I** |  |
| Preventive Care | 100% not subject to plan deductible |
| **Class II** |  |
| Basic Restorative | 80% after plan deductible |
| **Class III** |  |
| Major Restorative | 50% after plan deductible |
| **Class IV** |  |
| Orthodontia | 50% not subject to plan deductible |
| Class IV Orthodontia applies only to a Dependent Child less than 19 years of age. |  |
Cigna Dental Preferred Provider Insurance – Option 3 (If Applicable)

The Schedule

**For You and Your Dependents**
The Dental Benefits Plan offered by your Employer includes Participating and non-Participating Providers.

**Participating Provider Payment**
Participating Provider services are paid based on the Contracted Fee agreed upon by the provider and the Insurance Company.

**Non-Participating Provider Payment**
U.S. Non-Participating Provider services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is calculated at the 80th percentile of all provider charges in the geographic area.

<table>
<thead>
<tr>
<th>BENEFIT HIGHLIGHTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Classes I, II, III Combined Calendar Year Maximum</td>
<td>$1,500</td>
</tr>
<tr>
<td>Class IV Lifetime Maximum</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Class I</strong></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Class II</strong></td>
<td></td>
</tr>
<tr>
<td>Basic Restorative</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Class III</strong></td>
<td></td>
</tr>
<tr>
<td>Major Restorative</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Class IV</strong></td>
<td></td>
</tr>
<tr>
<td>Orthodontia</td>
<td>50%</td>
</tr>
<tr>
<td>Class IV Orthodontia applies only to a Dependent Child less than 19 years of age.</td>
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</tr>
</tbody>
</table>
Cigna Dental Preferred Provider Benefits (If Applicable)

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.

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.)

X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 3 calendar years.

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 – Only 1 treatment per tooth in any 3 calendar years.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.
Class II Services – Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery

Amalgam Filling

Composite/Resin Filling

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.

I. V. Sedation – 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.

Class III Services – Major Restorations, Dentures and Bridgework

Crowns

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-Fourths 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 5 calendar years old, is not serviceable and cannot be repaired.

Class IV Services – Orthodontics (Applicable only if Option 2 or 3 is Elected)

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.

The total amount payable for all expenses incurred for Orthodontics during a Dependent child's lifetime will not be more than the Orthodontia Maximum shown in the Schedule.
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;
- orthodontic treatment (Exclusion applies to Option 1 only);
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;
- services for which benefits are not payable according to the “General Limitations” section.
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.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared, riot, civil commotion or police action which occurs in the Employee’s country of citizenship.
- for claim payments that are illegal under applicable law.
- 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.
- 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 therapies or devices that are determined by the utilization review Physician to be:

- 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;
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- 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.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.

- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; 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. (Applicable only if Dental is Not Elected)
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- 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.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- 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, 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 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 wigs other than for scalp hair prostheses worn due to alopecia areata.

• hearing aids, including but not limited to, semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as covered under this plan as shown in the Covered Expenses section. A hearing aid is any device that amplifies sound.

• 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 except as shown in the Covered Expenses section for treatment of autism.

• eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

• all noninjectable prescription drugs, injectable prescription drugs that 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, weight loss programs and smoking cessation 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.

• 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 nonparticipating provider.

• medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating 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.

• 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 family or your Dependent's Family.

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.

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.

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. For claims incurred within the United States, you should file all claims under each Plan. For claims incurred outside the United States, if you file claims with more than one Plan, you must indicate, at the time of filing a claim under this Plan, that you also have or will be filing your claim under another 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, dental or vision care or treatment:
• Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
• Coverage under Medicare and other governmental benefits as permitted by law, except Medicaid and Medicare supplement policies.
• Medical benefits coverage of group, group-type, and individual automobile contracts.

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

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

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

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

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

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

Effect on the Benefits of This Plan

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

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

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

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
(b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
(c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;
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 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”,

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

Cigna will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.

- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.

- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

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

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

- 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.

Payment of Benefits – Medical

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 Dependent, you or your Dependents are responsible for reimbursing the provider.

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

When one of 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.

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.

Payment of Benefits – Vision

To Whom Payable

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

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

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal
Payment of Benefits – Dental (If Applicable)

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 Dependent, you or your Dependents are responsible for reimbursing the provider.

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

When one of 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.

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 date 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: (a) stops paying premium for you; or (b) otherwise 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 stops paying premium for you or otherwise 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.

Rescissions
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

Dental Benefits Extension (If Applicable)
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 prosthesis inserted 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.

Medical Benefits Extension

During Hospital Confinement Upon Policy Cancellation
If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy (except if policy is canceled for nonpayment of premiums) 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
- 10 days from the date the policy is canceled.
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 United States 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/Pharmacy Directories and Provider/Pharmacy Networks
A list of network providers and 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 providers, including hospitals, of varied specialties as well as general practice or pharmacies, affiliated or contracted with Cigna or an organization contracting on its behalf.

Qualified Medical Child Support Order (QMCSO)
Eligibility for Coverage Under a QMCSO
If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

Qualified Medical Child Support Order Defined
A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child’s right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child’s name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child’s mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits
Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child’s custodial parent or legal guardian, shall be made to the child, the child’s custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)
If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- Acquiring a new Dependent. If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage.
• **Loss of eligibility for State Medicaid or Children’s Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.

• **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan’s network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.

• **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee’s or Dependent’s other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).

• **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan’s service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer’s limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

• **Eligibility for employment assistance under State Medicaid or Children’s Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

**Effect of Section 125 Tax Regulations on This Plan**

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).
A. Coverage Elections
Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through H.

B. Change of Status
A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer’s network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

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

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

E. Change in Cost of Coverage
If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution. When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer’s Plan
You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

G. Reduction in work hours
If an Employee’s work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer’s coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in Qualified Health Plan (QHP)
The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace’s annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

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.
Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the “Newborns’ and Mothers’ Health Protection Act”: restrict benefits for any Hospital length of 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; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

Women’s Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

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.

Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, as amended, where applicable:

Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993, as amended; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return. You will not be required to satisfy any eligibility or benefit waiting period to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993, as amended.

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:

- 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.

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Claim Determination Procedures under ERISA
The following complies with federal law. Provisions of applicable laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations
In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.

Medical Necessity determinations are made on a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described below, in the Certificate, and in your provider’s network participation documents as applicable.

When services or benefits are determined to be not covered, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider’s network participation documents as applicable, and in the determination notices.

Preservice Determinations
When you or your representative requests a required prior authorization, Cigna will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond Cigna’s control, Cigna will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna will defer to the determination of the treating health care professional regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow Cigna’s procedures for requesting a required preservice medical necessity determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.
Concurrent Determinations
When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent coverage determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Determinations
When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna’s control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination
Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan’s review procedures and the time limits applicable, including a statement of a claimant’s rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, (if applicable); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; a description of any available internal appeal and/or external review process(es); information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

COBRA Continuation Rights Under Federal Law

For You and Your Dependents
What is COBRA Continuation Coverage?
Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a “qualifying event” that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan’s coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?
For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct, or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

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

Who is Entitled to COBRA Continuation?

Only a “qualified beneficiary” (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.
The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals’ coverage will terminate when your COBRA continuation coverage terminates. The sections titled “Secondary Qualifying Events” and “Medicare Extension For Your Dependents” are not applicable to these individuals.

Secondary Qualifying Events
If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension
If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:
- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA.

The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for “Termination of COBRA Continuation” listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents
When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation
COBRA continuation coverage will be terminated upon the occurrence of any of the following:
- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer’s policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer’s Service Area or Elimination of a Service Area
If you and/or your Dependents move out of the Employer’s service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer’s service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.
Employer’s Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse’s) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated.
back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

**You Must Give Notice of Certain Qualifying Events**

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

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

**Newly Acquired Dependents**

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

**COBRA Continuation for Retirees Following Employer’s Bankruptcy**

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

**Interaction With Other Continuation Benefits**

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

**ERISA Required Information**

Please see your Plan Administrator for the following information:

- The name of the Plan;
- The name, address, ZIP code and business telephone number of the sponsor of the Plan;
- Employer Identification Number (EIN);
- Plan Number;
- The name, address and zip code of the person designated as agent for legal process;
- How the cost of the Plan is paid;
- The Plan’s fiscal ending date.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

**Plan Trustees**

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

**Plan Type**

The plan is a healthcare benefit plan.

**Collective Bargaining Agreements**

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.
**Discretionary Authority**

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

**Plan Modification, Amendment and Termination**

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

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent’s total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan’s insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service (or later as explained in the Termination Section;)
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

**Statement of Rights**

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

**Receive Information About Your Plan and Benefits**

- examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 person under the Plan with a copy of this summary financial report.

**Continue Group Health Plan Coverage**

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit 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, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored 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.

**Enforce Your Rights**

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

In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or 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 listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
Notice of an Appeal or a Grievance

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

When You Have A Complaint Or An Appeal

For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

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

Start with Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you can call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form.

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

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

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing, within 365 days of receipt of a denial notice, to the following address:

Cigna
ATTN: Appeals Department
P.O. Box 15800
Wilmington, DE 19850

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

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional in the same or similar specialty as the care under consideration, as determined by Cigna’s Physician Reviewer.

For level one appeals, we will respond in writing with a decision within fifteen calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

Cigna’s Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

If the appeal involves a coverage decision based on issues of Medical Necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician or Dentist Reviewer in the same or similar specialty as the care under consideration, as determined by Cigna’s Physician or Dentist Reviewer. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was a) not involved in any previous decision related to your appeal, and b) not a subordinate of previous decision
makers. Provide all relevant documentation with your second-level appeal request.

For required preservice and concurrent care coverage determinations, Cigna’s review will be completed within 15 calendar days. For postservice claims, Cigna’s review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level-two appeal, Cigna will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the decision within five days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician Reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review of Medical Appeals

If you are not fully satisfied with the decision of Cigna's level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Health Care Appeals Program (IHCAP). The IHCAP is conducted by an Independent Utilization Review Organization (IYRO) assigned by the State of Delaware. A decision to use this level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. Cigna will abide by the decision of the Independent Utilization Review Organization.

In order to request a referral to an Independent Utilization Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within four months of your receipt of Cigna's level-two appeal review denial. Cigna will then forward the file to the Independent Utilization Review Organization.

The Independent Utilization Review Organization will render an opinion and provide written notice of its decision to the Participant or his/her authorized representative, the carrier and the Delaware Insurance Department within 45 calendar days of its receipt of the appeal. When requested and when the Participant suffers from a condition that poses an imminent, emergent or serious threat or has an emergency medical condition, the review shall be completed within 72 hours of the IYRO’s receipt of the appeal with immediate notification. The IYRO will provide written confirmation of its decision to the Participant or his/her authorized representative, the carrier, and the Delaware Insurance Department within 2 calendar days after the immediate notification.

Claim Appeal to the State of Delaware

You have the right to appeal a claim denial for non-medical reasons to the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services which are in addition to, but do not replace, your right to appeal this decision. You can contact the Delaware Insurance Department for information about an appeal or mediation by calling the Consumer Services Division at (302) 674-7310. You may go to the Delaware Insurance Department at The Rodney Building, 841 Silver Lake Blvd., Dover, DE 19904 between the hours of 8:30 a.m. and 4:00 p.m. to personally discuss the appeal or mediation process. You may also wish to submit a complaint by sending an email to the Delaware Insurance Department at consumer@state.de.us, or by using the complaint form, found at http://www.delawareinsurance.gov/complaint/complaintform.pdf and faxing the complaint to (302) 739-6278.

All appeals must be filed within 60 days from the date you receive this notice otherwise this decision will be final.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (5) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (6) upon request and free of charge, a copy of any internal rule, guideline,
protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and (7) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

**Relevant Information**

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

**Legal Action**

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level-One and Level-Two appeal processes. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action. However, no action will be brought at all unless brought within 3 years after a claim is submitted for U.S. In-Network Services or within three years after proof of claim is required under the Plan for U.S. Out-of-Network and International services.
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.

Certification
The term Certification means a decision by a health care insurer that a health care service requested by a provider or covered person has been reviewed and, based upon the information available, meets the health care insurer’s requirements for coverage and medical necessity, and the requested health care service is therefore approved.

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

Chiropractic Care
The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Contracted Fee - Cigna Dental Preferred Provider
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.

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.

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; 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 the Plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the Plan 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.

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.

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, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

Employer

The term Employer means the Policyholder and all Affiliated Employers.

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.

Expense Incurred

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

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.

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.

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.

Hospice Facility

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

- primarily provides care for Terminally Ill patients;
Maximum Reimbursable Charge – Dental
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 policyholder-selected 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 percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

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.

Medically Necessary/Medical Necessity
Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- 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; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies 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.

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.

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."

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

Optician
The term Optician means a fabricator and dispenser of eyeglasses and/or contact lenses. An optician fills prescriptions for glasses and other optical aids as specified by optometrists or ophthalmologists. The state in which an optician practices may or may not require licensure for rendering of these services.

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

Participating Pharmacy
The term Participating Pharmacy means a retail Pharmacy with which Cigna has contracted to provide prescription services to insureds, or a designated home delivery Pharmacy with which Cigna has contracted to provide home delivery prescription services to insureds. A home delivery Pharmacy is a Pharmacy that provides Prescription Drugs through mail order.

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.

Participating Provider - Cigna Dental Preferred 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.
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

The term Pharmacy means a retail Pharmacy, or a home delivery Pharmacy.

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

Prescription Drug means; a drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

Prescription Order

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

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

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

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.

**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.

**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.

**Vision Provider**

The term Vision Provider means: an optometrist, ophthalmologist, optician or a group partnership or other legally recognized aggregation of such professionals; duly licensed and in good standing with the relevant public licensing bodies to provide covered vision services within the scope of the Vision Providers’ respective licenses.
GROUP LIFE
INSURANCE CERTIFICATE

GLOBAL HEALTH ADVANTAGE
IMPORTANT NOTICES

The group policy is issued in the state of Delaware and will be governed by its laws.
FOREWORD

Life insurance provides individuals and their families with financial protection. The Life Insurance Benefit described in this booklet will help secure your family's financial security in the event of your death.

The need for life insurance protection depends on individual circumstances and financial situations. This valuable coverage should add an extra dimension to your personal insurance portfolio.
This certificate describes the benefits and basic provisions of your coverage. You should read it with care so you will understand your coverage.

This is not the insurance contract. It does not waive or alter any of the terms of the Policy. If questions arise, the Policy will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This certificate replaces any and all certificates which may have been issued to you in the past under the Policy.

These materials are being made available electronically for your convenience. Cigna has provided the final documents to your employer. Care should be taken to ensure you are reviewing the most complete, accurate and up to date version. Any questions regarding content may be directed to your employer or Cigna.

Mathew G. Mather, President

TL-004704
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SCHEDULE OF BENEFITS

Class Definition

You are eligible for insurance if you are a member of the class defined below.

All active, Full-time Expatriate, Third Country National and Select Key Local National Employees of a participating Employer regularly working a minimum of 30 hours per week outside the United States.

Your Eligibility Waiting Period

The Eligibility Waiting Period is the period of time you must be in Active Service to be eligible for coverage. It will be extended by the number of days you are not in Active Service.

If you were hired on or before the Policy Effective Date:
   No Waiting Period

If you were hired after the Policy Effective Date:
   No Waiting Period

LIFE INSURANCE BENEFITS

Employee Benefits

<table>
<thead>
<tr>
<th>Option 1 -</th>
<th>Flat benefit of $25,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 2 -</td>
<td>One (1) times your annual Basic Earnings (rounded to the next higher $1,000) up to a Maximum Amount of $200,000</td>
</tr>
<tr>
<td>Option 3 -</td>
<td>Two (2) times your annual Basic Earnings (rounded to the next higher $1,000) up to a Maximum Amount of $200,000</td>
</tr>
<tr>
<td>Option 4 -</td>
<td>One (1) times your annual Basic Earnings (rounded to the next higher $1,000) up to a Maximum Amount of $50,000</td>
</tr>
<tr>
<td>Option 5 -</td>
<td>Two (2) times your annual Basic Earnings (rounded to the next higher $1,000) up to a Maximum Amount of $400,000</td>
</tr>
</tbody>
</table>

Initial Amount of Life Insurance
For Options 2, 3, 4 and 5, your amount of Life Insurance on the day you become insured is based on your age and annual Basic Earnings on that day.

Age Based Reductions
If you are age 65 or older, your Life Insurance Benefits are payable as follows:

<table>
<thead>
<tr>
<th>Age 65 to 69</th>
<th>65% of Life Insurance Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 70 and over</td>
<td>50% of Life Insurance Benefits</td>
</tr>
</tbody>
</table>
ACCIDENT INSURANCE BENEFITS

Employee Benefits

<table>
<thead>
<tr>
<th>Amount of Insurance</th>
<th>Same as Life Insurance Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Based Reductions</td>
<td>Accident Insurance Benefits will reduce the same as Life Insurance Benefits</td>
</tr>
</tbody>
</table>

WHO IS ELIGIBLE

Classes of Eligible Persons

A person may be insured only once under the Policy, even though he or she may be eligible under more than one class. Persons for whom coverage is prohibited under applicable law will not be considered eligible under this policy.

EMPLOYEE

An Employee in one of the Classes of Eligible Employees shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date.

Persons for whom coverage is prohibited under applicable law will not be considered eligible under this policy.
WHEN COVERAGE BEGINS

You will be insured on the date you become eligible, if you are not required to contribute to the cost of this insurance.

An Employee who is required to contribute toward the cost of this insurance may elect insurance for himself only by authorizing payroll deduction in a form approved by the Employer and the Insurance Company. The effective date of this insurance depends on the date and amount of insurance elected.

If an enrollment form is received more than 31 days after an individual is eligible to elect coverage, this insurance will be effective on the date the Insurance Company agrees in writing to insure that eligible person.

If you are not in Active Service on the date insurance would otherwise go into effect, it will be effective on the date you return to Active Service.

WHEN COVERAGE ENDS

Coverage will end on the earliest of the following dates:

1. the date you are eligible for coverage under a plan intended to replace this coverage;
2. the date we terminate the Policy;
3. the date you are no longer in an eligible class;
4. the date coinciding with the end of the last period for which required premiums are paid;
5. the date you are no longer in Active Service; and
6. for an Employee, the date the Employer cancels participation under the Policy.

WHEN COVERAGE CONTINUES

Extended Death Benefit
If an Employee is under age 60 and his or her Active Service ends due to Disability and he or she is Disabled on the date his or her Life Insurance Benefits ends, the Insurance Company will continue his or her Life Insurance Benefits as shown in the Schedule of Benefits until the earlier of the following dates.

1. The date you are no longer Disabled.
2. 12 months after the date your Life Insurance Benefits would otherwise end.

Amount of Insurance
If the Employee dies during the period his or her Life Insurance Benefits are continued, the Insurance Company will pay the Life Insurance Benefit in effect on the day before he or she became Disabled. However, the Life Insurance Benefit payable will be subject to the provisions of the Policy that may reduce or terminate coverage on account of age, retirement or a change in eligible class.

“Disability”/”Disabled” means because of Injury or Sickness you are unable to perform all the material duties of your Regular Occupation; or are receiving disability benefits under the Employer’s plan.

“Regular Occupation” means the occupation you routinely perform at the time the Disability begins. We will consider the duties of the occupation as it is normally performed in the general labor market in the national economy.
WHAT IS COVERED

LIFE INSURANCE BENEFITS

Death Benefit
If an Insured dies, we will pay the Life Insurance Benefit in force for that Insured on the date of his or her death.

Conversion Privilege for Life Insurance Each Insured may convert all or any portion of his or her Life Insurance that would end under the Policy due to:

1. termination of employment;
2. termination of membership in an eligible class under the Policy;
3. termination of the Policy; or
4. reduction in insurance based on attained age.

The Insured may apply for any type of life insurance the Insurance Company offers to persons of the same age in the amount applied for, except the Insured may not:

1. choose term insurance;
2. apply for an amount of insurance greater than the coverage amount terminating under the Policy (also, the conversion policy will not provide accident, disability or other benefits); or
3. apply for more than $10,000 of insurance if the Policy is terminated or amended to terminate the insurance for any class of Insureds, or the Employer cancels participation under the Policy. Conversion in these cases is only permitted if the Insured has been covered by the Policy or, any group life insurance policy issued to the Employer which the Policy replaced, for at least 3 years.

If the Insured becomes eligible for coverage under any group life policy within 31 days of termination of coverage under this Policy, the Insured may not convert an amount of insurance greater than the amount of coverage terminating under the Policy less the amount for which he or she may be covered under the other policy.

To apply for conversion insurance, the Insured must, within 31 days after coverage under the Policy ends:

1. submit an application to the Insurance Company; and
2. pay the required premium.

Evidence of insurability is not required.
WHAT IS COVERED

LIFE INSURANCE BENEFITS

(Continued)

Premium for the conversion insurance will be based on the age and class of risk of the Insured and the type and amount of coverage issued.
If the Insured has assigned ownership of his group coverage, the owner/assignee must apply for the individual policy.
Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends provided the application is received by the Insurance Company and the required premium has been paid.
If the Insured dies during the 31-day conversion period, the Life Insurance benefits will be paid under the Policy regardless of whether he or she applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any further benefits for that type and amount of insurance from this Policy.

Extension of Conversion Period
If an Insured is eligible for conversion insurance and is not notified of this right at least 15 days prior to the end of the 31-day conversion period, the conversion period will be extended. The Insured will have 15 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 90 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Employer or mailed to the Insured's last known address as reported by the Employer.

If the Insured dies during the extended conversion period, but more than 31 days after his or her coverage under the Policy terminates, Life Insurance benefits:

1. will not be paid under the Policy; and
2. will be payable under the conversion insurance; provided:
   a. the Insured's application for conversion insurance has been received by the Insurance Company; and
   b. the required premium has been paid.

Prior Conversion Limitation
If an Insured is covered under a life insurance conversion policy previously issued by the Insurance Company, he or she will not be eligible for this Conversion Privilege unless the prior coverage has ended.
WHAT IS NOT COVERED
LIFE EXCLUSIONS

No benefits are payable for war or an act of war, whether or not declared or active participation in a riot which occurs in the Insured’s country of citizenship.

No benefits are payable for an insured on full-time active duty for more than 30 days in the Armed Forces of any nation. (If the Insured sends proof of service, the Insurance Company will refund any premiums paid for coverage during this time. Reserve or National Guard active duty or training are not excluded unless it extends beyond 31 days.)

No benefits are payable for claim payments that are illegal under applicable law.

TL-004752.CGHB
ACCIDENT INSURANCE BENEFITS

If you are an Employee and insured under the Policy for Accident Insurance on the date of an Accident, we will pay the Accident Insurance Benefits for a loss shown in the Schedule of Losses. If more than one loss results from the same Accident, we will pay only the largest Benefit Amount to which you are entitled. The loss must be a result of bodily Injuries caused directly, and from no other causes, by an Accident, and must occur within 365 days of the Accident.

**Schedule of Losses**

<table>
<thead>
<tr>
<th>Schedule of Losses</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life, or Two Members</td>
<td>100%</td>
</tr>
<tr>
<td>One Member</td>
<td>50%</td>
</tr>
<tr>
<td>Thumb and Index Finger of the Same Hand</td>
<td>25%</td>
</tr>
</tbody>
</table>

"Member" means a hand, foot or the entire sight of an eye. Loss of a hand or foot means complete Severance through or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

"Severance" means the complete separation and dismemberment of the part from the body.
WHAT IS NOT COVERED

ACCIDENT EXCLUSIONS

The Insurance Company will not pay Accident Insurance Benefits for a loss which in any way results directly or indirectly from any of the following.

1. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane (except in Missouri, this applies only while sane).

2. Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a doctor. (Accidental ingestion of a poisonous substance is not excluded.)

3. Sickness, disease or bodily infirmity; medical or surgical treatment; or bacterial or viral infection, no matter how contracted. (This does not include bacterial infection that is the natural and foreseeable result of an accidental bodily injury or accidental food poisoning.)

4. While an Insured is on full-time active duty for more than 30 days in any Armed Forces. (If the Insured sends proof of service, the Insurance Company will refund any premiums paid for coverage during this time. Reserve or National Guard active duty or training are not excluded unless it extends beyond 31 days.)

5. Travel or flight in, or getting in or out of: an aircraft being used for test or experiment; an aircraft the Insured is flying, is learning to fly, or is part of the crew of; a military aircraft, other than transport aircraft flown by the U.S. Air Mobility Command (AMC) or a similar air transport service of another country; an aircraft owned or leased by or for the Employer, its subsidiaries or affiliates, or the Insured or a member of his or her household; an aircraft that does not have a valid FAA normal or transport type certificate of airworthiness; or an aircraft that is not flown by a pilot with a valid license.


7. No benefits are payable for war or an act of war, whether or not declared or active participation in a riot which occurs in the Insured’s country of citizenship.

8. No benefits are payable for claim payments that are illegal under applicable law.
CLAIM PROVISIONS

Notice of Claim
Written notice of claim, or notice by any other electronic/telephonic means authorized by us, must be given to us within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by us, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's name, the Policy Number and the claimant's name and address.

Claim Forms
When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision
If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data
The Employer is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the Employer in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss
You must provide written proof of loss to us, or proof by any other electronic/telephonic means authorized by us, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by us, must be given not more than one year after the 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is provided outside of these time limits, the claim will be denied. These time limits will not apply due to lack of legal capacity.
Time of Payment
Benefits due under the Policy for a loss, other than a loss for which the Policy provides installment payments, will be paid immediately upon receipt of due written proof of such loss.

Subject to the receipt of satisfactory written proof of loss, all accrued benefits for loss for which the Policy provides installment payments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof, unless otherwise stated in the Description of Benefits.

To Whom Payable
Death Benefits will be paid to the Insured's named beneficiary, if any, on file at the time of payment or to the certificate owner if alive. If there is no named beneficiary or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives: spouse; child or children; mother or father; brothers or sisters; or to the executors or administrators of the Insured's estate. We may reduce the amount payable by any indebtedness due.

All other benefits unless otherwise stated in the Policy, will be payable to the Insured or the certificate owner if other than the Insured.

Any other accrued benefits which are unpaid at your death will, at our option, be paid either to your beneficiary or to the executor or administrator of your estate.

If we pay benefits to the executor or administrator of your estate or to a person who is incapable of giving a valid release, we may pay up to $1,000 to a relative by blood or marriage whom we believe is equitably entitled. This good faith payment satisfies our legal duty to the extent of that payment.

Change of Beneficiary
You may change your beneficiary at any time by giving written notice to the Employer or to us. The beneficiary's consent is not required for this or any other change which you may make unless your designation of beneficiary is irrevocable.

No change in beneficiary will take effect until the form is received by the Employer or us. When this form is received, it will take effect as of the date of the form. If you die before the form is received, we will not be liable for any payment that was made before receipt of the form.

Physical Examination and Autopsy
We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

Legal Actions
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by us, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.
CLAIM PROVISIONS
(Continued)

Time Limitations
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship
You have the right to choose any Physician who is practicing legally. We will in no way disturb the Physician/patient relationship.
ADMINISTRATIVE PROVISIONS

Premiums
The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If the Insured's coverage amount is reduced due to his or her attained age, premium will be based on the amount of coverage in force on the day after the reduction took place.

Reinstatement of Insurance
Your coverage may be reinstated without satisfying the Insurability Requirement, if your insurance ends because you are on an unpaid leave of absence and you apply for Reinstatement within 31 days of your return to Active Service.

After your insurance ends, it may be reinstated at any date prior to five years after the date of termination if the following conditions are met.

1. The Policy is still in force.
2. You are eligible under the Policy.
3. You send us a written request for reinstatement and a new enrollment form.
4. The required premium is paid.
5. The Insurability Requirement, if applicable, is satisfied.

GENERAL PROVISIONS

Incontestability
All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for insurance.

Misstatement of Age
If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Assignment of Benefits
We will not be affected by the assignment of your certificate until the original assignment or a certified copy of the assignment is filed with us. We will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.
GENERAL PROVISIONS
(Continued)

Clerical Error
A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Ownership of Records
All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Accident
The term Accident means a sudden, unforeseeable external event that causes you bodily Injury and occurs while your coverage is in force under the Policy.

Active Service
If you are an Employee, you are in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. You are actively at work. This means you are performing your regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.

2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

You are considered in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Annual Compensation
Annual Compensation means an Employee's annual wage or salary as reported by the Employer for work performed for the Employer as of the date the covered loss occurs. It does not include amounts received as bonuses, commissions, overtime pay or other extra compensation.

Employee
For eligibility purposes, you are an Employee if you work for the Employer and are in one of the "Classes of Eligible Employees." Otherwise, you are an Employee if you are an employee of the Employer who is insured under the Policy.

Employer
The Employer who has subscribed to the Policyholder and for the benefit of whose Employees this policy has been issued. The Employer, named as the Subscriber on the front of this Policy, includes any affiliates or subsidiaries covered under the Policy. The Employer is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the Employer as actions of the Insurance Company.
DEFINITIONS
(Continued)

Full-time
Full-time means the number of hours set by the Employer as a regular work day for Employees in your eligibility class.

Injury
Any accidental loss or bodily harm that results directly and independently from all other causes from an Accident.

Insurability Requirement
An eligible person satisfies the Insurability Requirement for an amount of coverage on the day we agree in writing to accept you as insured for that amount. To determine a person's acceptability for coverage, we will require you to provide evidence of good health and may require it be provided at your expense.

Insurance Company
The Insurance Company underwriting the Policy is named on your certificate cover page. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

Insured
You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.

Physician
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in your household.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Employer and in effect directly prior to the Policy Effective Date.

Sickness
The term Sickness means a physical or mental illness.
SUPPLEMENTAL INFORMATION
for
Employee Benefits Plan
required by the Employee Retirement
Income Security Act of 1974

As a Plan participant in your Company’s Insurance Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

You should refer to the attached Certificate for a description of when you will become eligible under the Plan, the amount and types of benefits available to you, and the circumstances under which benefits are not available to you or may end. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

IMPORTANT INFORMATION ABOUT THE PLAN

Please see your Plan administrator for the following information:

- The Plan is established and maintained by the Plan Sponsor.
- The Employer Identification Number (EIN)
- The Plan Number
- The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract issued by LIFE INSURANCE COMPANY OF NORTH AMERICA.
- The Plan Administrator has authority to control and manage the operation and administration of the Plan.
- The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)
- The agent for service of legal process is the Plan Administrator.
- How the Plan of Benefits is financed.
- The date of the end of the Plan Fiscal Year.
YOUR RIGHTS AS SET FORTH BY ERISA

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

**Receive Information About Your Plan and Benefits**

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**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 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. 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 Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.
WHAT YOUR BENEFICIARY SHOULD DO AND EXPECT IF HE/SHE HAS A CLAIM

When your beneficiary is eligible to receive benefits under the Plan, a request must be made for a claim form or to obtain instructions for submitting a claim telephonically or electronically, from the Plan Administrator. All claims submitted must be on the claim form or in the electronic or telephonic format provided by the Insurance Company. A claim must be completed according to directions provided by the Insurance Company. If these forms or instructions are not available, a written statement of proof of loss must be provided. After a claim form or written statement has been completed, it must be submitted to the Plan Administrator.

The Plan Administrator has appointed the Insurance Company as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

Review of Claims for Benefits

The Insurance Company has 45 days from the date it receives a claim for disability benefits, or 90 days from the date it receives a claim for any other benefit, to determine whether or not benefits are payable in accordance with the terms of the Policy. The Insurance Company may require more time to review the claim if necessary due to matters beyond its control. If this should happen, the Insurance Company must provide notice in writing that its review period has been extended for up to two more 30 day periods (in the case of a claim for disability benefits); or 90 days more (in the case of any other benefit). If this extension is made because additional information must be furnished, these extension periods will begin when the additional information is received. The requested information must be furnished within 45 days.

During the review period, the Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify the Insured of the date and time of the examination and the physician's name and location. If additional information is required, the Insurance Company must notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, the Insurance Company will pay the appropriate benefit.

If the claim is denied, in whole or in part, the Insurance Company will provide written notice within the review period. The Insurance Company's written notice will include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for the claim to be reconsidered, and the reason this information is necessary.
4. In the case of any claim for a disability benefit: identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
5. A statement regarding the right to appeal the decision, and an explanation of the appeal procedure, including a statement of the right to bring a civil action under Section 502(a) of ERISA if the appeal is denied.
APPEAL PROCEDURE FOR DENIED CLAIMS

Whenever a claim is denied, there is the right to appeal the decision. A written request for appeal must be made to the Insurance Company within 60 days from the date the denial was received. If a request is not made within that time, the right to appeal will have been waived.

Once a request has been received by the Insurance Company, a prompt and complete review of the claim will take place. This review will give no deference to the original claim decision. It will not be made by the person who made the initial claim decision, or a subordinate of that person. During the review, the claimant (or the claimant’s duly authorized representative) has the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. Issues and comments that might affect the outcome of the review may also be submitted.

The Insurance Company has 60 days from the date it receives a request to review the claim and provide its decision. Under special circumstances, the Insurance Company may require more time to review the claim. If this should happen, the Insurance Company must provide notice, in writing, that its review period has been extended for an additional 60 days. Once its review is complete, the Insurance Company must state, in writing, the results of the review and indicate the Plan provisions upon which it based its decision.
UNDERWRITTEN BY:
LIFE INSURANCE COMPANY OF NORTH AMERICA
a Cigna company

01/2016
GROUP LONG TERM DISABILITY INSURANCE CERTIFICATE
This certificate provides disability insurance for the employees under the Employer’s group policy. The employee shall be given a copy of the group enrollment application. Coverage will begin according to the terms set forth in the Eligibility and Effective Date provisions.

Please refer to the sticker located inside the cover of this booklet for the effective date of this plan, the Elimination Period Selected by your Employer, and whether you are required to contribute towards the cost of your insurance.

We certify that we insure all eligible persons, who are enrolled according to the terms of the Group Policy. Your coverage will begin according to the terms set forth in the Eligibility and Effective Date provisions.

This certificate describes the benefits and basic provisions of your coverage. You should read it with care so you will understand your coverage.

This is not the insurance contract. It does not waive or alter any terms of the Policy. If questions arise, the Policy will govern. You may examine the Policy at the office of the Policyholder or the Administrator.

This certificate replaces any and all certificates which may have been issued to you in the past under the Group Policy.

These materials are being made available electronically for your convenience. Cigna has provided the final documents to your employer. Care should be taken to ensure you are reviewing the most complete, accurate and up to date version. Any questions regarding content may be directed to your employer or Cigna.
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SCHEDULE OF BENEFITS

Eligible Class Definition: All Full-time Expatriate and Third Country National Employees of a participating Employer working at least 30 hours a week outside the United States as reported by the policyholder.

Eligibility Waiting Period

If you were hired on or before the Policy Effective Date: None

If you were hired after the Policy Effective Date: None

Elimination Period

Option I – 90 days or 180 days
Option II – 90 days or 180 days

Gross Disability Benefit

Option I - The lesser of 60% of your monthly Covered Earnings rounded to the nearest dollar or the Maximum Disability Benefit.

Option II – The lesser of 66 2/3% of your monthly Covered Earnings rounded to the nearest dollar or the Maximum Disability Benefit.

Maximum Disability Benefit

Option I - $5,000 per month
Option II - $10,000 per month

Minimum Disability Benefit

Option I - $50 per month
Option II - $100 per month

Disability Benefit Calculation

The Disability Benefit payable to you is figured using the Gross Disability Benefit, Other Income Benefits and the Return to Work Incentive. Monthly Benefits are based on a 30-day month. The Disability Benefit will be prorated if payable for any period less than a month.

During any month you have no Disability Earnings, the monthly benefit payable is the Gross Disability Benefit less Other Income Benefits. During any month the Employee has Disability Earnings, benefits are determined under the Return to Work Incentive. Benefits will not be less than the minimum benefit shown in the Schedule of Benefits except as provided under the section Minimum Benefit.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that you receive on your own behalf or for your dependents, or which your dependents receive because of your entitlement to Other Income Benefits.
SCHEDULE OF BENEFITS

Return to Work Incentive
During any month you have Disability Earnings, your benefits will be calculated as follows.

Your monthly benefit payable will be calculated as follows during the first 24 months disability benefits are payable and you have Disability Earnings:

1. Add your Gross Disability Benefit and Disability Earnings.
2. Compare the sum from 1. to your Indexed Earnings.
3. If the sum from 1. exceeds 100% of your Indexed Earnings, then subtract the Indexed Earnings from the sum in 1.
4. Your Gross Disability Benefit will be reduced by the difference from 3., as well as by Other Income Benefits.
5. If the sum from 1. does not exceed 100% of your Indexed Earnings, your Gross Disability Benefit will be reduced by Other Income Benefits.

After disability benefits are payable for 24 months, the monthly benefit payable is the Gross Disability Benefit reduced by Other Income Benefits and 50% of Disability Earnings.

No Disability Benefits will be paid, and insurance will end if the Insurance Company determines you are able to work under a modified work arrangement and you refuse to do so without Good Cause.
**Additional Benefits**

**Survivor Benefit**

<table>
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<tr>
<th>Amount of Benefit:</th>
<th>100% of the sum of the last full Disability Benefit plus the amount of any Disability Earnings by which the benefit had been reduced for that month.</th>
</tr>
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<tr>
<td>Maximum Benefit Period:</td>
<td>A single lump sum payment equal to 3 monthly Survivor Benefits.</td>
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**Maximum Benefit Period**

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<tr>
<th>Age When Disability Begins</th>
<th>Maximum Benefit Period</th>
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<td>Age 62 or under</td>
<td>Your 65th birthday or the date the 42nd Monthly Benefit is payable, if later.</td>
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<td>Age 63</td>
<td>The date the 36th Monthly Benefit is payable.</td>
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<tr>
<td>Age 64</td>
<td>The date the 30th Monthly Benefit is payable.</td>
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<tr>
<td>Age 65</td>
<td>The date the 24th Monthly Benefit is payable.</td>
</tr>
<tr>
<td>Age 66</td>
<td>The date the 21st Monthly Benefit is payable.</td>
</tr>
<tr>
<td>Age 67</td>
<td>The date the 18th Monthly Benefit is payable.</td>
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<tr>
<td>Age 68</td>
<td>The date the 15th Monthly Benefit is payable.</td>
</tr>
<tr>
<td>Age 69 or older</td>
<td>The date the 12th Monthly Benefit is payable.</td>
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WHO IS ELIGIBLE

If you qualify under the Class Definition shown in the Schedule of Benefits you are eligible for coverage under the Policy on the Policy Effective Date.

TL-004710

WHEN COVERAGE BEGINS

You will be insured on the date you become eligible. You may be required to contribute to the cost of your insurance. See your Employer for additional information or refer to the sticker located inside the front cover of this certificate.

TL-004712

WHEN COVERAGE ENDS

Your coverage ends on the earliest of the following dates:
1. the date you are eligible for coverage under a plan intended to replace this coverage;
2. the date the Policy is terminated;
3. the date you are no longer in an eligible class;
4. the day after the end of the period for which premiums are paid;
5. the date you are no longer in Active Service;
6. the date you refuse to participate in rehabilitation efforts as required by the insurance policy;
7. the date you refuse to comply with a plan of Appropriate Care;
8. the date you are no longer receiving Appropriate Care.

If you are entitled to receive Disability Benefits when the Policy terminates, Disability Benefits will be payable to you if you remain disabled and meet the requirements for the insurance. Any later period of Disability, regardless of cause, that begins when you are eligible under another disability coverage provided by any employer, will not be covered.

TL-007505.00
WHEN COVERAGE CONTINUES

This provision modifies the When Coverage Ends provision to allow insurance to continue under certain circumstances if you are no longer in Active Service. Insurance that is continued under this provision is subject to all other terms of the When Coverage Ends provisions.

Your Disability Insurance will continue if your Active Service ends because of a Disability for which benefits under the Policy are or may become payable. Your premiums will be waived while Disability Benefits are payable. If you do not return to Active Service, this insurance ends when your Disability ends or when benefits are no longer payable, whichever occurs first.

If your Active Service ends due to personal or family medical leave approved timely by the Employer, insurance will continue for you for up to 12 weeks, if the required premium is paid when due.

If your Active Service ends due to any other leave of absence approved in writing by the Employer prior to the date you cease work insurance will continue for you for up to 12 weeks if the required premium is paid. An approved leave of absence does not include layoff or termination of employment.

If your Active Service ends due to any other excused short term absence from work that is reported to the Employer timely in accordance with the Employer’s reporting requirements for such short term absence, your insurance will continue until the earlier of:
   a. the date your employment relationship with the Employer terminates;
   b. the date premiums are not paid when due;
   c. the end of the 30 day period that begins with the first day of such excused absence;
   d. the end of the period for which such short term absence is excused by the Employer.

Notwithstanding any other provision of this policy, if your Active Service ends due to layoff, termination of employment, or any other termination of the employment relationship, insurance will terminate and continuation of insurance under this provision will not apply.

If your insurance is continued pursuant to this When Coverage Continues provision, and you become Disabled during such period of continuation, Disability Benefits will not begin until the later of the date the Elimination Period is satisfied or the date you are scheduled to return to Active Service.

TL-004716
DESCRIPTION OF BENEFITS
WHAT IS COVERED

Disability Benefits
We will pay Disability Benefits if you become Disabled while covered under this Policy. You must satisfy the Elimination Period, be under the Appropriate Care of a Physician, and meet all the other terms and conditions of the Policy. You must provide to us, at your own expense, satisfactory proof of Disability before benefits will be paid. The Disability Benefit is shown in the Schedule of Benefits.

We will require continued proof of your Disability for benefits to continue.

Elimination Period
The Elimination Period is the period of time you must be continuously Disabled before Disability Benefits are payable. The Elimination Period is shown in the Schedule of Benefits.

A period of Disability is not continuous if separate periods of Disability result from unrelated causes.

Disability Benefit Calculation
The Disability Benefit Calculation is shown in the Schedule of Benefits. Monthly Disability Benefits are based on a 30 day period. They will be prorated if payable for any period less than a month. If an Employee is working while Disabled, the Disability Benefit Calculation will be the Return to Work Incentive.

Return to Work Incentive
The Return to Work Incentive is shown in the Schedule of Benefits. An Employee may work for wage or profit while Disabled. In any month in which the Employee works and a Disability Benefit is payable, the Return to Work Incentive applies.

We will, from time to time, review your status and will require satisfactory proof of earnings and continued Disability.

Minimum Benefit
We will pay the Minimum Benefit shown in the Schedule of Benefits despite any reductions made for Other Income Benefits. The Minimum Benefit will not apply if benefits are being withheld to recover an overpayment of benefits.
DESCRIPTION OF BENEFITS
WHAT IS COVERED

Other Income Benefits
An Employee for whom Disability Benefits are payable under this Policy may be eligible for benefits from Other Income Benefits. If so, the Insurance Company may reduce the Disability Benefits by the amount of such Other Income Benefits.

Other Income Benefits include:

1. any amounts received (or assumed to be received*) by you or your dependents under:
   - the Canada and Quebec Pension Plans;
   - the Railroad Retirement Act;
   - any local, state, provincial or federal government disability or retirement plan or law payable for Injury or Sickness provided as a result of employment with the Employer;
   - any sick leave or salary continuation plan of the Employer;
   - any work loss provision in mandatory "No-Fault" auto insurance.

2. any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive*) on your own behalf or for your dependents; or which your dependents receive (or are assumed to receive*) because of your entitlement to such benefits.

3. any Retirement Plan benefits funded by the Employer. "Retirement Plan" means any defined benefit or defined contribution plan sponsored or funded by the Employer. It does not include an individual deferred compensation agreement; a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 40l(k) plan.

4. any proceeds payable under any franchise or group insurance or similar plan. If other insurance applies to the same claim for Disability, and contains the same or similar provision for reduction because of other insurance, we will pay for our pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.

5. any amounts received (or assumed to be received*) by you or your dependents under any workers’ compensation, occupational disease, unemployment compensation law or similar state or federal law payable for Injury or Sickness arising out of work with the Employer, including all permanent and temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.

6. any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.

Dependents include any person who receives (or is assumed to receive*) benefits under any applicable law because of your entitlement to benefits.

*See the Assumed Receipt of Benefits provision.
DESCRIPTION OF BENEFITS
WHAT IS COVERED

Increases in Other Income Benefits
Any increase in Other Income Benefits during a period of Disability due to a cost of living adjustment will not be considered in calculating your Disability Benefits after the first reduction is made for any Other Income Benefits. This section does not apply to any cost of living adjustment for Disability Earnings.

Lump Sum Payments
Other Income Benefits or earnings paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated over five years.

If no specific allocation of a lump sum payment is made, then the total payment will be an Other Income Benefit.

Assumed Receipt of Benefits
We will assume you (and your dependents, if applicable) are receiving benefits for which you are eligible from Other Income Benefits. We will reduce your Disability Benefits by the amount from Other Income Benefits we estimate are payable to you and your dependents.

We will waive Assumed Receipt of Benefits, except for Disability Earnings for work you perform while Disability Benefits are payable, if you:

1. provide satisfactory proof of application for Other Income Benefits;
2. sign a Reimbursement Agreement;
3. provide satisfactory proof that all appeals for Other Income Benefits have been made unless we determine that further appeals are not likely to succeed; and
4. submit satisfactory proof that Other Income Benefits were denied.

We will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until you actually receive them.

Social Security Assistance
We may help you in applying for Social Security Disability Income (SSDI) Benefits, and may require you to file an appeal if we believe a reversal of a prior decision is possible.

We will reduce Disability Benefits by the amount we estimate you will receive, if you refuse to cooperate with or participate in the Social Security Assistance Program.

Recovery of Overpayment
We have the right to recover any benefits we have overpaid. We may use any or all of the following to recover an overpayment:

1. request a lump sum payment of the overpaid amount;
2. reduce any amounts payable under this Policy; and/or
3. take any appropriate collection activity available to us.

The Minimum Benefit amount will not apply when Disability Benefits are reduced in order to recover any overpayment.
DESCRIPTION OF BENEFITS
WHAT IS COVERED

If an overpayment is due when you die, any benefits payable under the Policy will be reduced to recover the overpayment.

Successive Periods of Disability
A separate period of Disability will be considered continuous:
1. if it results from the same or related causes as a prior Disability for which benefits were payable; and
2. if, after receiving Disability Benefits, you return to work in your Regular Occupation for less than 6 consecutive months; and
3. if you earn less than the percentage of Indexed Earnings that would still qualify you to meet the definition of Disability/Disabled during at least one month.

Any later period of Disability, regardless of cause, that begins when you are eligible for coverage under another group disability plan provided by any employer will not be considered a continuous period of Disability.

For any separate period of disability which is not considered continuous, you must satisfy a new Elimination Period.
LIMITATIONS

Limited Benefit Periods
We will pay Disability Benefits on a limited basis for a Disability caused by, or contributed to by, any one or more of the following conditions. Once 24 monthly Disability Benefits have been paid during your lifetime, no further benefits will be payable for any of the following conditions:

1. Alcoholism
2. Anxiety disorders
3. Delusional (paranoid) disorders
4. Depressive disorders
5. Drug addiction or abuse
6. Eating disorders
7. Mental illness
8. Somatoform disorders (psychosomatic illness)

If, before reaching your lifetime maximum benefit, you are confined in a hospital for more than 14 consecutive days, that period of confinement will not count against your lifetime limit. The confinement must be for the Appropriate Care of any of the conditions listed above.

Pre-existing Condition Limitation

- The Insurance Company will not pay benefits for any period of Disability caused or contributed to by, or resulting from a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which the Insured incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within (12) months before his most recent effective date of insurance.

- The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you have been in Active Service for a continuous period of (6) months during which you have received no medical treatment, care or services in connection with the pre-existing condition. or are covered for at least (24) months after your most recent effective date of insurance, or the effective date of any added or increased benefits.
ADDITIONAL BENEFITS

Rehabilitation During a Period of Disability
If we determine that you are a suitable candidate for rehabilitation, we may require you to participate in a Rehabilitation Plan and assessment at our expense. We have the sole discretion to approve your participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan. We will work with you, the Employer and your Physician and others, as appropriate, to perform the assessment, develop a Rehabilitation Plan, and discuss return to work opportunities.

The Rehabilitation Plan may, at our discretion, allow for payment of your medical expense, education expense, moving expense, accommodation expense or family care expense while you participate in the program.

If you fail to fully cooperate in all required phases of the Rehabilitation Plan and assessment without Good Cause, no Disability Benefits will be paid, and insurance will end.

Survivor Benefit
We will pay a Survivor Benefit if you die while Monthly Benefits are payable. You must have been continuously Disabled before the first benefit is payable. These benefits will be payable for the Maximum Benefit Period for Survivor Benefits.

We will pay the Survivor Benefit to your Spouse. If you do not have a Spouse, we will pay your surviving Children in equal shares. If you do not have a Spouse, or any Children, we will pay your estate.

"Spouse" means your lawful spouse. "Children" means your unmarried children under age 21 who are chiefly dependent upon you for support and maintenance. The term includes a stepchild living with you at the time of your death.
TERMINATION OF DISABILITY BENEFITS

Benefits will end on the earliest of the following dates:
1. the date you earn from any occupation, more than the percentage of Indexed Earnings set forth in the definition of Disability applicable to you at that time;
2. the date we determine you are not Disabled;
3. the end of the Maximum Benefit Period;
4. the date you die;
5. the date you refuse, without Good Cause, to fully cooperate in all required phases of the Rehabilitation Plan and assessment;
6. the date you are no longer receiving Appropriate Care;
7. the date you fail to cooperate with us in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.
8. the date you refuse, without Good Cause, to fully cooperate in a Transitional Work Arrangement;
9. the date you return to Active Service;
10. the date you are able to work at your Regular Occupation the lesser of eight hours per day and forty hours per week, or, the number of hours per day and per week defined by your Employer as the full-time requirement for your occupation.

Benefits may be resumed if you begin to cooperate fully in the Rehabilitation Plan within 30 days of the date benefits terminated.

WHAT IS NOT COVERED

The Insurance Company will not pay any Disability Benefits for a Disability that results, directly or indirectly, from:

1. suicide, attempted suicide, or self-inflicted injury while sane or insane;

2. war or any act of war, whether or not declared;

3. terrorism or active participation in a riot;

4. Injury or Sickness while the Employee is serving on full-time active duty in any armed forces. If the Employee sends proof of service, the Insurance Company will refund pro rata the premium paid to cover the Employee during a period of such service;

5. commission of a felony;
WHAT IS NOT COVERED

6. any cosmetic surgery or surgical procedure that is not Medically Necessary; "Medically Necessary" means the surgical procedure is: (a) prescribed by a Physician as required treatment of the Injury or Sickness; and (b) appropriate according to conventional medical practice for the Injury or Sickness in the locality in which the surgery is performed. The Insurance Company will pay benefits if the Disability is caused by the Employee's donating an organ in a non-experimental organ transplant procedure;

7. being under the influence of a controlled substance (unless administered by a Physician or taken according to a Physician's instructions) or being intoxicated. "Intoxicated" means that condition as defined by the law of the jurisdiction in which the activity or event occurred;

8. the revocation, restriction or non-renewal of an Employee’s license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy.

The Insurance Company will not pay benefits for claim payments that are illegal under applicable law.

In addition, the Insurance Company will not pay Disability Benefits for any period of Disability during which an Employee is incarcerated in a penal or corrections institution for any reason.
CLAIM PROVISIONS

Notice of Claim
Written notice of claim, or notice by any other electronic/telephonic means authorized by us, must be given to us within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by us, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office or to our agent. Notice should include the Employer's name, the Policy Number and the claimant's name and address.

Claim Forms
When we receive notice of claim, we will send claim forms for filing proof of loss. If we do not send claim forms within 15 days after notice is received by us, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by us, of the nature and extent of the loss.

Claimant Cooperation Provision
If you fail to cooperate with us in our administration of your claim, we may terminate the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data
The Employer is required to cooperate with us in the review of claims and applications for coverage. Any information we provide to the Employer in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss
You must provide written proof of loss to us, or proof by any other electronic/telephonic means authorized by us, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by us, must be given not more than one year after the 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is provided outside of these time limits, the claim will be denied. These time limits will not apply due to lack of legal capacity.

Written proof that the loss continues, or proof by any other electronic/telephonic means authorized by us, must be furnished to us at intervals we require. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to us.

Time of Payment
Disability Benefits will be paid at regular intervals of not less frequently than once a month. Any balance, unpaid at the end of any period for which we are liable, will be paid at that time.
CLAIM PROVISIONS

To Whom Payable
Disability Benefits will be paid to you. If any person to whom benefits are payable is a minor or, in our opinion is not able to give a valid receipt, such payment will be made to his or her legal guardian. However, if no request for payment has been made by the legal guardian, we may, at our option, make payment to the person or institution appearing to have assumed custody and support.

If you die while any Disability Benefits remain unpaid, we may, at our option, make direct payment to any of your following living relatives: your spouse, your mother, your father, your children, your brothers or sisters; or to the executors or administrators of your estate. We may reduce the amount payable by any indebtedness due.

Payment in the manner described above will release us from all liability for any payment made.

Physical Examination and Autopsy
We may, at our expense, exercise the right to examine any person for whom a claim is pending as often as we may reasonably require. Also, we may, at our expense, require an autopsy unless prohibited by law.

Legal Actions
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by us, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.

Time Limitations
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which you live when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship
You have the right to choose any Physician who is practicing legally. We will in no way disturb the Physician/patient relationship.
ADMINISTRATIVE PROVISIONS

Premiums
The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

Reinstatement of Insurance
Your coverage may be reinstated if your insurance ends because you are on an Employer approved unpaid leave of absence. Your insurance may be reinstated only if reinstatement occurs within 12 weeks from the date it ends due to an Employer approved unpaid leave of absence or must be returning from military service pursuant to the Uniformed Services Employment Act of 1994 (USERRA).

For your insurance to be reinstated the following conditions must be met.
1. You must qualify under the Class Definition.
2. The required premium must be paid.
3. A written request for reinstatement and a new enrollment form for you must be received by us within 31 days from the date you return to Active Service.

Your reinstated insurance is effective on the date you return to Active Service. If you did not fully satisfy your Eligibility Waiting Period or Pre-Existing Condition Limitation (if any) before your insurance ended due to an unpaid leave of absence, you will receive credit for any time that was satisfied.

GENERAL PROVISIONS

Incontestability
All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for insurance.

Misstatement of Age
If an Insured's age has been misstated, we will adjust all benefits to the amounts that would have been purchased for the correct age.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Assignment of Benefits
We will not be affected by the assignment of your certificate until the original assignment or a certified copy of the assignment is filed with us. We will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.
GENERAL PROVISIONS

Clerical Error
A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Accident. An Accident is a sudden unforeseeable external event that causes bodily injury to an Insured while coverage is in force under the Policy.

Active Service
If you are an Employee, you are in Active Service on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. You are performing your regular occupation for the Employer on a full-time basis. You must be working at one of the Employer's usual places of business or at some location to which the Employer's business requires you to travel.
2. The day is a scheduled holiday or vacation day and you were performing your regular occupation on the preceding scheduled work day.

You are in Active Service on a day which is not one of the Employer's scheduled work days only if you were in Active Service on the preceding scheduled work day.

Appropriate Care
Appropriate Care means the determination of an accurate and medically supported diagnosis of your Disability by a Physician, or a plan established by a Physician of ongoing medical treatment and care of your Disability that conforms to generally accepted medical standards, including frequency of treatment and care.

Consumer Price Index (CPI-W)
The Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the index is discontinued or changed, another nationally published index that is comparable to the CPI-W will be used.

Covered Earnings
Covered Earnings means your wage or salary as reported by the Employer for work performed for the Employer as in effect just prior to the date your Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the date of the change, if the Employer gives us written notice of the change and the required premium is paid.

It does not include any amounts received as bonus, commissions, overtime pay or other extra compensation.

Any increase in your Covered Earnings will not be effective during a period of continuous Disability.
DEFINITIONS

Disability/Disabled
You are considered Disabled if, solely because of Injury or Sickness, you are:
1. unable to perform the material duties of your Regular Occupation; and
2. unable to earn 80% or more of your Indexed Earnings from working in your Regular Occupation.

After Disability Benefits have been payable for 24 months, you are considered Disabled if, solely due to Injury or Sickness, you are:
1. unable to perform the material duties of any occupation for which you are, or may reasonably become, qualified based on education, training or experience; and
2. unable to earn 60% or more of your Indexed Earnings.

We will require proof of earnings and continued Disability.

Disability Earnings
Any wage or salary for any work performed for any employer during your Disability, including commissions, bonus, overtime pay or other extra compensation.

Employee
For eligibility purposes, you are an Employee if you work for the Employer and are in one of the "Classes of Eligible Employees." Otherwise, you are an Employee if you are an employee of the Employer who is insured under the Policy.

Employer
The Policyholder and any affiliates or subsidiaries covered under the Policy. The Employer is acting as your agent for transactions relating to this insurance. You shall not consider any actions of the Employer as actions of the Insurance Company.

Full-time
Full-time means the number of hours set by the Employer as a regular work day for Employees in your eligibility class.

Good Cause
A medical reason preventing participation in the Rehabilitation Plan. Satisfactory proof of Good Cause must be provided to us.

Indexed Earnings
For the first 12 months Monthly Benefits are payable, your Indexed Earnings are equal to your Covered Earnings. After 12 Monthly Benefits are payable, your Indexed Earnings are your Covered Earnings plus an increase applied on each anniversary of the date Monthly Benefits became payable. The amount of each increase will be the lesser of:
1. 10% of your Indexed Earnings during your preceding year of Disability; or
2. the rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Injury
Any accidental loss or bodily harm that results directly and independently from all other causes from an Accident.
DEFINITIONS

Insurability Requirement
An eligible person satisfies the Insurability Requirement for an amount of coverage on the day we agree in writing to accept you as insured for that amount. To determine a person's acceptability for coverage, we will require you to provide evidence of good health and may require it be provided at your expense.

Insurance Company
The Insurance Company underwriting the Policy is named on your certificate cover page. References to the Insurance Company have been changed to "we", "our", "ours", and "us" throughout the certificate.

Insured
You are an Insured if you are eligible for insurance under the Policy, insurance is elected for you, the required premium is paid and your coverage is in force under the Policy.

Physician
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include you, your spouse, your immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in your household.

Policy Anniversary
A Policy Anniversary is the date stated on the Policy cover and the same date that follows every 12 months for as long as the Policy is in effect.

Policy Effective Date
The Policy Effective Date is the date stated on the Policy cover.

Policyholder
A Policyholder is an Employer who has applied for coverage under the Policy for his eligible Employees and their dependents.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits to you, sponsored by the Employer and in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of a company in effect on the day prior to that company's addition to this Policy after the Policy Effective Date.

Regular Occupation
The occupation you routinely perform at the time the Disability begins. In evaluating the Disability, we will consider the duties of the occupation as it is normally performed in the general labor market in the national economy. It is not work tasks that are performed for a specific employer or at a specific location.

Rehabilitation Plan
A written plan designed to enable you to return to work. The Rehabilitation Plan will consist of one or more of the following phases:
1. rehabilitation, under which we may provide, arrange or authorize education, vocational or physical rehabilitation or other appropriate services;
2. work, which may include modified work and work on a part-time basis.

Sickness
The term Sickness means a physical or mental illness.
AMENDATORY RIDER
DOMESTIC PARTNER COVERAGE

Policy No. 12345A                                          Effective Date: January 1, 2014

This rider amends the Policy and Certificate to which it is attached. It is effective on the Effective Date shown above, and expires when the Policy expires.

A. Domestic Partner means any of the following:

1. A person with whom the Employee has a registered domestic partnership under state law which imposes legal obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Domestic Partner Partner unless and until: (1) the domestic partnership is dissolved under applicable law; or (2) either the Employee or the Domestic Partner marries another person.

2. A person who was legally married to the Employee under the laws of a state permitting marriage of partners of the same sex, where the Employee and Domestic Partner currently reside in a state that does not recognize a valid marriage. This shall not apply if:
   a. the marriage has been terminated by legal process, or;
   b. either the Employee or the Domestic Partner has entered into a valid marriage, or domestic partnership under state law.

3. A person meeting all of the following requirements, with respect to an Employee:
   a. Shares a permanent residence with the Employee;
   b. Has resided with the Employee for at least 6 months and is expected to continue to reside with the Employee indefinitely;
   c. Has not been legally married to any other person within the previous six months, and has no Domestic Partner other than the Employee during the previous six months, and is the Employee’s sole Domestic Partner;
   d. Has signed a Domestic Partner declaration with the Employee, if the Employee resides in a jurisdiction which provides for Domestic Partner declarations;
   e. Has not signed a Domestic Partner declaration with any other person within the last 6 months;
   f. Is interdependent with the Employee in three or more of the following ways:
      1. Both partners are registered under any municipal ordinance as domestic partners.
      2. Both partners are jointly parties to a lease, mortgage or deed.
      3. Both partners jointly own one or more motor vehicles.
      4. Both partners jointly own one or more bank or credit accounts.
      5. The Employee has named the Domestic Partner as attorney-in-fact under a durable power of attorney with authority over health care decisions.
      6. The Employee has designated the Domestic Partner as beneficiary under a retirement plan or a life insurance policy.
      7. The Employee has designated the Domestic Partner as beneficiary of the Employee’s will.
      8. Each partner has agreed in writing to assume the financial responsibility for the welfare of the other.
   g. Is not so closely related by blood to the Employee as to prohibit legal marriage in their state of residence;
   h. Is no less than 18 years of age.

The Employee and Domestic Partner must furnish the Employer and Insurance Company with a signed declaration that the above requirements are met, and an agreement to notify the Employer and Insurance Company if the requirements cease to be met, on a form acceptable to the Employer and Insurance Company.

B. The Survivor Benefit is modified in the Policy and Certificate as follows:
AMENDATORY RIDER
DOMESTIC PARTNER COVERAGE

1. All references to the term “Spouse” are replaced by "Spouse or Domestic Partner " except for the following references:
   a. The first reference to “Spouse” in the Survivor Benefit text is changed to “Spouse, or Domestic Partner” if there is no Spouse”.
   b. The text pertaining to the definition of “Spouse” remains unchanged.

C. Survivor benefits will be payable as follows: (1) to the Employee’s spouse or Domestic Partner; (2) if there is none, in equal shares to the Employee’s surviving Children; or (3) if there is none, to the Employee’s estate.

D. A child of a Domestic Partner may only be eligible for benefits if:
   a. the child is primarily dependent on the Employee for financial support;
   b. the Employee has a legal obligation of support of the child;
   c. the Employee is the child’s legal guardian.

Except for the above this rider does not change the Policy or Certificate to which it is attached.

LIFE INSURANCE COMPANY OF NORTH AMERICA

Matthew G. Manders, President

TL-007153
SUPPLEMENTAL INFORMATION
for
Employee Benefits Plan
required by the Employee Retirement
Income Security Act of 1974

As a Plan participant in your Company’s Insurance Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

You should refer to the attached Certificate for a description of when you will become eligible under the Plan, the amount and types of benefits available to you, and the circumstances under which benefits are not available to you or may end. The Certificate, along with the following Supplemental Information, makes up the Summary Plan Description as required by ERISA.

IMPORTANT INFORMATION ABOUT THE PLAN
Please see your Plan administrator for the following information:
• The Plan is established and maintained by the Plan Sponsor.

• The Employer Identification Number (EIN)

• The Plan Number

• The Insurance Plan is administered directly by the Plan Administrator with benefits provided, in accordance with the provisions of the group insurance contract issued by LIFE INSURANCE COMPANY OF NORTH AMERICA.

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

• The Plan Sponsor may terminate, suspend, withdraw or amend the Plan, in whole or in part, at any time, subject to the applicable provisions of the Policy. (Your rights upon termination or amendment of the Plan are set forth in your Certificate.)

• The agent for service of legal process is the Plan Administrator.

• How the Plan of benefits is financed.

• The date of the end of the Plan Fiscal Year.
WHAT YOU SHOULD DO AND EXPECT IF YOU HAVE A CLAIM

When you are eligible to receive benefits under the Plan, you must request a claim form or obtain instructions for submitting your claim telephonically or electronically, from the Plan Administrator. All claims you submit must be on the claim form or in the electronic or telephonic format provided by the Insurance Company. You must complete your claim according to directions provided by the Insurance Company. If these forms or instructions are not available, you must provide a written statement of proof of loss. After you have completed the claim form or written statement, you must submit it to the Plan Administrator.

The Plan Administrator has appointed the Insurance Company as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

The Insurance Company has 45 days from the date it receives your claim for disability benefits, or 90 days from the date it receives a claim for any other benefit, to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Policy. The Insurance Company may require more time to review your claim if necessary due to circumstances beyond its control. If this should happen, the Insurance Company must notify you in writing that its review period has been extended for up to two additional periods of 30 days (in the case of a claim for disability benefits), or one additional period of 90 days (in the case of any other benefit). If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You have up to 45 days to furnish the requested information.

During the review period, the Insurance Company may require a medical examination of the Insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Insurance Company will notify you of the date and time of the examination and the physician’s name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Insurance Company must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the appropriate benefit from the Insurance Company.

If your claim is denied, in whole or in part, you must receive a written notice from the Insurance Company within the review period. The Insurance Company’s written notice must include the following information:

1. The specific reason(s) the claim was denied.
2. Specific reference to the Policy provision(s) on which the denial was based.
3. Any additional information required for your claim to be reconsidered, and the reason this information is necessary.
4. In the case of any claim for a disability benefit, identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
5. A statement informing you of your right to appeal the decision, and an explanation of the appeal procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA if your appeal is denied.
**Appeal Procedure for Denied Claims**

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by the Insurance Company, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. You may also submit issues and comments that you feel might affect the outcome of the review.

The Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision (45 days, in the case of any claim for disability benefits). Under special circumstances, the Insurance Company may require more time to review your claim. If this should happen, the Insurance Company must notify you, in writing, that its review period has been extended for an additional 60 days (45 days in the case of any claim for disability benefits). Once its review is complete, the Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

**YOUR RIGHTS AS SET FORTH BY ERISA**

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

**Receive Information About Your Plan and Benefits**

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
**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 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. 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 Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit 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 Benefit Security Administration.
APPENDIX N

Phased Retirement Policy

Eligibility
The employee must meet all of the following:
1) Currently be a full-time benefits-eligible faculty or staff employee, or be a faculty member currently on Associate Status; AND
2) Currently be at least age 59.5; AND
3) Have worked for a minimum of ten years past the age of 45 in a benefits-eligible status; AND
4) Receive VP approval in writing.

Work/Retirement Commitment
Eligible employee must agree to a reduced work schedule of between .5 and .6 full-time equivalent (FTE) for a maximum of 36 months, and to then retire fully from employment.

Pay and Benefits
During the phased retirement (part-time work) period:
• the employee receives pro-rated salary;
• retirement plan contributions and CTO accrual (if applicable) are based on actual, pro-rated FTE/pay; and
• health and welfare benefits are maintained:
  o the employee pays for medical insurance at the reduced salary level (resulting in a significant premium savings), and
  o the employee’s life and disability benefits continue at the (higher) pre-Phased Retirement salary level, and
  o the employee has the ability to begin withdrawing funds from his/her Core and/or Voluntary Retirement Plans, while still working part-time.

Agreement
In order to take advantage of this program, the employee and the Employer must enter into an irrevocable Phased Retirement Agreement under which the employee consents to reduce to a specific work schedule of between .5 and .6 FTE, as well as establish a specific retirement date, which retirement date can be no more than 36 months in the future. It is important to note that while the employee can request a specific retirement date, as well as a specific FTE, VP approval is required for a Phased Retirement Agreement, so the FTE and the duration of employment stipulated in the Agreement is at the discretion of the VP.

Staff employees who are interested in learning more about Phased Retirement should contact the Human Resources Department; faculty employees are encouraged to contact the Dean of the Faculty’s Office.
APPENDIX O

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 P

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).
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. 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 dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-802-443-5465.

ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईंको निम्नित्ता भाषा सहायता सेवाहरू निःशुल्क रुपमा उपलब्धछ। फोन गर्नुहोस् 1-802-443-5465.


XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 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.

لمحوزة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم هاتف الصم والبكم. 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.
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、お電話にてご連絡ください。

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